POST-TRAUMATIC

STRESS DISORDER

IN

A GROUP OF SEXUALLY ABUSED

CHILDREN

Dissertation submitted for the
M. Phil. Degree in Child Psychiatry
by Dr Joan Westaway

ACKNOWLEDGEMENTS

I would like to thank:

Dr Carl Ziervogel, my supervisor, for all the assistance that I have received from him throughout our association. His quietly efficient supervision in this and other projects has been greatly valued.

Glenda Raad, my dear friend, who has given unstintingly of her time and expertise in the preparation of these pages. Her love and encouragement have sustained me through many a difficult period.

Gisèle Raad, who shares my interest in human nature and whose lively questions and comments have been an inspiration in so many facets of my work. Her commitment and past contributions towards the well-being of children will always be remembered.

Lastly, but most importantly, my husband, **John Cavvadas**, whose patience, affection, wisdom and support have made it possible for me to meet the emotional demands of this career.

December 1993

ABSTRACT

It is apparent that many South African children experience potentially traumatising events, such as rape, in the course of their lives.

It is also evident that stress reactions in certain South African children are not being identified.

The purpose of this dissertation is:

1. to expose and document P.T.S.D. in children whose circumstances and behaviour may have concealed the severity of their reactions to stress.

2. to improve assessment and management of children in similar situations.

In order to increase levels of awareness about stress reactions in children, a review is presented which deals with current assessment criteria of P.T.S.D., the wide-ranging phenomenology of stress reactions in children, the variable course of these reactions and the impact of several confounding factors on manifestations of post-traumatic stress.

The review is followed by case studies of P.T.S.D. in a group of 6 sexually abused female children at a children's home.

Careful documentation of the cases revealed how stress reactions had been incorrectly labelled or overlooked by professionals for lengthy periods and how the children tended to suppress or conceal their symptoms.

Indirect methods of eliciting information about the children's functioning appeared more successful in assessment then conventional interviews.

Comments on these findings and recommendations are made in the discussion.

It is concluded that severe stress reactions in children have been missed in situations which perpetuate social disadvantage for the traumatised child.

A large scale search for similar cases is urgently needed.

Case findings and management may require a skilled professional approach which allows for the child's sensitivity to being stigmatised.

PLATE I

The angry, fearful child

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Note 1: **Font and Style**

- **Bold print** denotes highlighted features in the text;
- **Italics** denote terms of art, colloquialisms, quotations, names of newspapers, and terms having a special connotation;
- **Italics between quotation marks** denote quotations within quotations.

Note 2: **Abbreviation**

- In the greater part of the text, the abbreviation **P.T.S.D**. has been used for Post-Traumatic Stress Disorder.

"We must organise our thinking

about childhood trauma

or we run the risk of

never seeing the condition at all"

(Terr, 1991)

The above statement was made by Leonore Terr, the presenter of the Samuel G. Hibbs Lecture at the 140th annual meeting of the American Psychiatric Association in Chicago.

INTRODUCTION

(A) CURRENT INTEREST IN CHILDHOOD STRESS REACTIONS

In the last two decades there have been impressive advances in the field of traumatic stress research.

Recently investigators have become particularly interested in **psychic trauma in children.**

The inquiry in this field has been fuelled by **findings linking childhood trauma to psychopathology in adulthood** (Ross, 1991; Kuch, 1992; Mullen, 1993).

Prominent writers have offered explanations for disordered personality development after profound stress. Some have postulated **psychological and social processes** as mechanisms of change (Terr, 1991). Others have invoked **neurobiological effects on the developing organism,** which they believe might be as profoundly far reaching as alteration in gene expression (Post, 1992).

Whatever the pathogenesis of disordered adult states after psychic trauma, there seems little doubt that some of the answers are to be found in the **study of children's stress reactions.**

(B) IDENTIFYING A PSYCHIATRIC DISORDER IN CHILDREN

The acceptance of the D.S.M.-111 **diagnostic criteria** for **POST-TRAUMATIC STRESS DISORDER** (1980) as useful in children has made it easier to identify stress reactions in them and enabled researchers to study the childhood presentations of this disorder in a variety of situations.

The findings thus far have given rise to concern, as **P.T.S.D. appears to be a serious psychiatric disorder in childhood.** It is believed to be a more prevalent disorder in children than was once thought (McLeer, 1992), and, disturbingly, treatment modalities used in certain situations have not proved particularly beneficial (Dreman, 1990; Terr, 1993).

Of particular concern are the recent reports of the high frequency of P.T.S.D. **in sexually abused children** (McLeer, 1988, 1991), and the finding that the full blown disorder is resistant to many of the treatment programmes currently being offered in these cases.

The investigators have repeatedly referred to clinicians' unwillingness to accept psychic trauma in children (Benedek, 1985), their **failure to diagnose stress reactions in childhood** (McLeer, 1988), and to the fact that the recognition of P.T.S.D. requires a proactive approach (Eldridge, 1991).

(C) QUESTIONS ABOUT SOUTH AFRICAN CHILDREN

In the light of these alarming disclosures about the prevalence and **apparent neglect of this serious disorder** of childhood in other parts of the world, there are obvious questions which we should be asking about P.T.S.D. in the **children of our country,** where young people are exposed to a **variety of catastrophic stressors**, yet there is little information about their reactions to these experiences.

Among the traumas which many South African children have endured, and continue to face, are those which repeatedly threaten the child's existence, let alone the safety of family members. A recent situational analysis of women and children in South Africa by UNICEF has revealed horrifying statistics of violent causes of death in children (Patel, 1993).

In the past year **4000 rape cases** have been reported to the Child Protection Unit, involving children below the age of 14 years. These figures appear to represent only **the tip of the iceberg** (report on page 8, *Cape Times,* 11th June, 1993).

Family murders have become commonplace events, (report on page 1, *Cape Argus,* 24th August, 1992; and report on page 1, *Cape Times,* 26th August, 1992), not to mention other forms of **domestic violence** to which children are continually being exposed (report on page 13, *The Argus,* 5th May, 1993).
Lastly, there is the **ongoing civil and political violence** which has resulted in the so-called *marginalised* youth of our country and formed the backdrop for **other brutalising experiences.**

It is clear that the circumstances favour the occurrence of numerous cases of P.T.S.D. in South African children, yet they have not become known to professionals.

Some of the questions which need to be answered are the following:

- Are professionals overlooking P.T.S.D. in South African children?
- If so, what are the difficulties in case finding?
- What are the consequences of missing P.T.S.D. for certain children?
- How do the presentations vary?
- What clinical course do cases follow?
- What interventions have been used, if any?
- Are the current approaches to traumatised children appropriate?
- Do the children have special mental health needs?
- How should these needs be addressed?

We are a long way from being able to answer these questions, but there is a need to direct **attention to this area of inquiry.** The documentation of experience related to P.T.S.D. in South African children has become a matter of urgency.

SUBJECT CHOICE, TITLE, SCOPE and PURPOSE

Subject choice:
This dissertation addresses the presentation and course of **Post-Traumatic Stress Disorder** in children. The subject has particular relevance in South Africa because many young people are exposed to catastrophic stressors. In all likelihood the disorder is prevalent in this country, but largely concealed. In the wider research arena, the field is one which continues to invite exploration. Several investigators have expressed the ongoing need to evaluate children for the presence of P.T.S.D. in multiple settings and in commonly occurring stressful situations in childhood.

Title:
The title is intended to convey the context of the presentations of Post-Traumatic Stress Disorder in the cases studied.

Scope and purpose of the dissertation:
Part I of the dissertation will consist of a literature review on the historical background, clinical manifestations and course of Post-Traumatic Stress Disorder in children with particular reference to those aspects of the diagnosis which have been problematic in clinical practice and which may lead to failure to recognise the disorder.

Special attention will be given to the following:

1. The historical determinants of our clinical orientation;
2. Factors which alter the clinical presentation of the disorder and create diagnostic difficulties;
3. New approaches, concepts, e.g. Type I and Type II traumas;
4. Current knowledge of outcome.

The purpose of the review is to increase levels of awareness and clinical insight in our work with traumatised children.

In **Part II** of the dissertation the presentations and clinical course of Post-Traumatic Stress Disorder in a group of six sexually-abused children at a children's home will be described. The description of the cases will include all the presenting features and not only those which are considered relevant to the diagnosis of Post-Traumatic Stress Disorder.

The purpose of the case presentations will be :

1. To examine the difficulties and delay in the recognition of P.T.S.D. in this group of children;

2. To make observations on the presentations and clinical course of the disorder in these children;

3. To comment on the implications of the findings, e.g., the possible consequences of overlooking psychic trauma in these circumstances;

4. To examine critically some of the current approaches to traumatised children, particularly their placement in protective environments e.g. children's homes;

5. To offer practical suggestions for meeting the special needs of children in similar circumstances.

In **Part III** of the dissertation the findings of the study will be discussed. Recommendations will be made on the basis of case findings.

PART I

CHAPTER 1

A HISTORICAL PERSPECTIVE ON POST-TRAUMATIC STRESS DISORDER AND ITS RECOGNITION IN CHILDREN

1.1. Historical context

The diagnosis, **Post-Traumatic Stress Disorder,** has evolved against a background of adult suffering. In serving adult interests, the investigation of the disorder has followed a particular course. A historical perspective will be presented which outlines this course and shows how the exploration of childhood psychic trauma occurred in the wake of **adult stress research.**

It is hoped that this account will draw attention to aspects of the research which, while greatly contributing to our knowledge of post-traumatic stress reactions in general, has not facilitated the recognition of hidden psychic trauma in children, particularly those in disadvantaged environments.

The concept of psychological trauma is at least 100 years old, but for the greater part of this period its meaning has been somewhat vague. **The following factors stimulated the refinement of this concept and gave it status in the field of psychiatry:**

- In 1893 the **first organised theory of psychological reaction to trauma** was formulated by Joseph Breuer and Sigmund Freud. This theory was based on their work with somatic symptoms in women (Breuer and Freud, 1893/1955). In 1920 Freud defined psychic trauma as ***"a breach in an otherwise efficacious barrier against stimuli"***. This clear definition proved valuable as a basis for the current understanding of psychological injury (Freud, 1920);

- During the same period **the legal system demanded delineation of predictable psychological reactions to trauma,** for the establishment of guidelines in industrial accident claims (Horowitz, 1986);

- Subsequently the devastating psychological effects of large-scale wars mobilised research and sadly provided a testing ground for **theories of combat stress reactions;**

- Between World War 1 and the Vietnam War **the recognition that stress reactions to war were universal** (Horowitz, 1986, p.17) and not necessarily a manifestation of mental *weakness*, created a shift away from earlier psychoanalytic models of individual pathology toward more cognitive models of stress-response. The changes in terminology from *war neurosis* to *combat exhaustion* reflected this trend in conceptualisation (Peebles, 1989) and laid the foundation for the current diagnostic term;

- Finally, in 1980 after the Vietnam War and following advancements in psychiatric nosology, the American Psychiatric Association introduced the term, **Post-Traumatic Stress Disorder** in D.S.M.-111 (Spitzer, 1980).

1.2. The advent of a new diagnosis

The diagnosis Post-traumatic Stress Disorder legitimised the suffering of Vietnam war veterans and resulted in the recognition of compensation claims for the disorder (Horowitz, 1986). Post-Traumatic Stress Disorder has been described as a *modern buzzword* (Peebles, 1989), but it has certainly generated intense interest in human suffering over a wide area and has resulted in the accumulation of a vast amount of literature on traumatic stress. Information is now available on the aetiology, assessment and treatment of Post-Traumatic Stress Disorder in individuals exposed to a wide variety of stressors, e.g. torture, rape, assault, sexual abuse, natural disasters, industrial accidents, etc.

1.3. Adult research kindles an interest in childhood trauma

Fortunately, in the midst of this activity, some researchers turned their attention to the manifestations of the disorder in children (Terr, 1981, 1983, 1985; Pynoos, 1987). It will be noted from the above account that adult demands played a significant role in the evolution and establishment of Post-Traumatic Stress Disorder as a respectable diagnostic category for adult stress reactions. The same cannot be said for the early exploration of psychic trauma in children. It has required the dedicated efforts of a few child-orientated research workers to attract attention to this important area of investigation.

1.4. Early inquiry into childhood psychic trauma

Prior to the last two decades, interest in children's reactions to severely traumatising events was minimal and the opinion was held that children's responses reflected parent-child interactions (Terr, 1987a).

1.5. Post-war studies

There were some noteworthy exceptions in the quest for knowledge about children in the *quiet* 25-year period, which followed World War 11. **The**

first of these contributions dealt with children's experiences of war, but the researchers tended to focus on how children fared without their parents, rather than their unique responses to events. Based on their findings in British children who had been evacuated from London during the bombings and young Holocaust survivors, Anna Freud and the Hampstead group suggested that children reacted to catastrophic events in ways similar to adults (Freud and Burlingham, 1943). One worker's observations revealed specific differences in children's memories of events as compared with adults (Kennedy, 1950). This finding is regarded as having a bearing on current studies (Terr, 1987a).

A second large-scale study was conducted in peacetime and examined children's reactions to a disaster which occurred when a killer-tornado struck a local theatre while the children were watching a Saturday matinee (Block, 1956). However, parents and not children were interviewed in this study.

One prominent American author was instrumental in sensitising the paediatric profession to the frightening experience of hospitalisation in children, but his concept of trauma was too broad to fit into current definitions (Levy, 1945). The importance of this contribution was Levy's focus on the frightened children themselves.

1.6. *Stress and coping* - the focus of the 1960's

During the 1960's there were descriptions of children who had survived the Holocaust and Hiroshima (Sterba, 1968; Lifton, 1967). Lifton was able to demonstrate how long the effects of massive childhood trauma could last (Terr, 1987a). Despite these valuable observations on psychic trauma, the bulk of the research undertaken in the 60's was on *stress and coping* and the findings fostered optimistic attitudes, which persisted in subsequent investigations (Garmezy, 1983).

1.7. *On-site* studies in the 1970's

A number of *disaster* studies followed in the 1970's. These included an account of symptoms manifested by children whose school was engulfed by a coal tip in Aberfan (Lacey, 1972). In some studies traumatised children themselves were interviewed. (Newman, 1976; Terr, 1979). These *on-site* studies were the first to undertake direct contact between the interviewer and the child. A recent historical review has drawn attention to the importance of talking to children in P.T.S.D. research. Udwin points out that previous studies relied on adult information, which, for various reasons, has not proved satisfactory in the past (Udwin, 1992; Terr, 1993).

It would certainly appear that, prior to interviews with children about their reactions to stress, the extent of their suffering was unknown to adult investigators.

1.8. The acceptance of the D.S.M.-111 criteria in children

Since 1980 there has been a rapid acceleration in the accumulation of knowledge about traumatic stress in children. The extent of this information will be revealed in other sections of this review. Importantly during this decade a number of studies demonstrated the overall adequacy of the D.S.M.-111 criteria for P.T.S.D. for children (Pynoos, 1987), although several modifications were included in D.S.M.-111-R (Spitzer, 1987). As a result of the acceptance of these criteria, P.T.S.D. is now a well known disorder in children, even in pre-school children who have been found to suffer similar reactions to adults (Udwin, 1992: Terr, 1993).

1.9. Direction of childhood studies

Following adult studies, disaster and sexual abuse were targeted as research topics in young people, but recently new avenues of exploration have opened in the area of childhood injury, assault, loss and the witnessing of violence (Malmquist, 1986; Pynoos, 1988; Payton 1988; Kiser, 1991).
With the acceleration of violent behaviour in the U.S.A. and elsewhere, scientists have become increasingly interested in the nature of aggression and its psycho biological activation (Lewis, 1992; Eichelman, 1992).

There is now abundant evidence of the association of aggressive behaviours with a history of maltreatment (Cicchetti, 1989). Since the prevalence of violence has generated interest in its prevention and control, the implications for current studies in children are obvious.

1.10. South African studies

In South-Africa the dimensions of violence in all its forms have become alarming (*Cape Times*, August 26, 1992) but it is the political violence and its effects which have attracted the most attention for study in children (Dawes, 1990; Gibson, 1987, 1989; Shmukler, 1990; Straker, 1987, 1990; Swartz, 1989; Dowdall, 1990).

Post-Traumatic Stress Disorder has been described in South African children who have been exposed to political violence (Straker, 1990). The fact that in many of these cases the stressors are multiple and ongoing has been emphasised by Straker.

Although childhood trauma in general has reached epidemic proportions in South Africa (*Cape Times*, February 9, 1993), the psychological reactions of children to these traumatic events had until recently received little attention (Appelbaum, 1993).

A recent study of 35 traumatised South African children and adolescents revealed typical presentations of post-traumatic stress disorder in a variety of situations involving catastrophic violence. It was the opinion of the authors that debriefing interviews were helpful in the management of these cases (Smith, 1993).

In accordance with international trends, sexual abuse in children has attracted public interest and there are indications that childhood sexual abuse is prevalent in South Africa (Levett, 1991). It has also been observed that violent sexual assault may be problematic in certain black communities (Jacob, 1989).

Child abuse in Soweto is presently reaching astronomical proportions. By far the most common form of child abuse encountered in the clinics serving Soweto is child sexual abuse. In a two-year period, 1300 sexually abused children were examined in the clinic (Bomvana, 1993).

Despite these observations, there have not been any major studies on post-traumatic stress reactions to abuse in South African children.

1.11. Towards the recognition of all traumatised children

The perspective which has been presented will reveal that the focus of investigation into childhood trauma has tended to be on spectacular events and their impact on groups of children. The examination of trauma in this way has highlighted findings in a somewhat dramatic manner. This *"hammer effect"* (Pynoos, 1985) of examining catastrophic trauma in groups of children has been useful in promoting an interest in the subject and establishing the validity of the diagnosis of Post-Traumatic Stress Disorder in childhood. However, the direction of this inquiry may have attracted attention away from the personal distress of countless young people in less dramatic circumstances, whose suffering appears to have been concealed from adults or simply overlooked by them.

The identification of the severely traumatised child who is not part of a group, remains a problem.

Furthermore, in this country it would appear that the endurance of stress has become a way of life for many children. Their extreme reactions to events may easily form part of the general backdrop of violence and despair, escaping the notice of even the few who are trained to recognise their suffering.

The results of scientific inquiry have yet to be translated into timely recognition of all traumatised children and to lead to effective intervention strategies.

In concluding this historical perspective, I refer again to Terr's lecture (Terr, 1991) and to her words: "***We must not let ourselves forget childhood trauma just because the problem is so vast.***"

CHAPTER 2:

THE CLINICAL PRESENTATION OF POST-TRAUMATIC STRESS DISORDER IN CHILDREN

2.1. Limitation of current concepts

The current literature on Post-Traumatic Stress Disorder in children focuses largely on the nature of the trauma and the delineation of trauma-related symptoms in various situations. However, most studies have not specifically dealt with the presence or absence P.T.S.D. as currently defined (Spitzer, 1987). Therefore, the extent to which children experience the P.T.S.D. symptomatology is still unclear.

The following account of the clinical features of P.T.S.D. in children reflects the present state of knowledge on the subject, given the above limitations.

2.2. General phenomenology of P.T.S.D. in childhood

Clinical observations of P.T.S.D. in children consistently list the following symptoms (Kiser, 1991):

- Development of **trauma-related** and/or mundane **fears;**
- **Sleep disturbances,** including difficulty in going to bed, falling asleep, sleeping in strange places, climbing into bed with a parent;
- **Nightmares** and night terrors;
- Regressive **bed-wetting,** thumb-sucking;
- **Eating** disturbances;
- **Guilt;**
- **Acting out or withdrawal behaviour;**
- **Depressive** behaviours;
- **Mistrust;**
- **Irritability.**

(Goodwin, 1985; Lindberg, 1985; Terr, 1983; Pynoos, 1988).

The other characteristic symptoms of P.T.S.D are those which typically occur in adult sufferers and which are also cited in children:

- **Persistent re-experiencing of the traumatic event;**
- **Persistent avoidance of stimuli associated with the trauma;**
- **General numbing of responsiveness;**
- **Persistent symptoms of increased arousal.**

Although the overall adequacy of the D.S.M.-111 adult criteria (American Psychiatric Association, 1987) for P.T.S.D. has been accepted (Benedek, 1985; Pynoos, 1987), several modifications were included in D.S.M.-111-R (American Psychiatric Association, 1987) based on clinical descriptions reported in the literature to reflect factors that may have an influence on symptom presentation in children.

These include the following:

- **Re-experiencing** the event through repetitive play;
- Containing **themes** or aspects of the trauma;
- Loss of newly acquired developmental skill or **regression** to an earlier level of development as manifested by withdrawal and **diminished interest** in significant activities;
- A **sense of foreshortened future** and/or an ability to achieve expected life goals in career and family;
- **Omen formation;**
- Psychological symptoms such as separation-anxiety, **generalised fear,** and/or personality changes.

Brett et al (1988) listed the above characteristics in their review of P.T.S.D. in children.

Based on her extensive studies of young people exposed to trauma, (Terr, 1983a, b; 1985, 1987b) **Terr** proposes an expanded list of diagnostic criteria and presents **differential criteria for Type I and Type II disorders** (Terr, 1987). These proposals will be discussed further under the subtitle ***Newer concepts***.

Terr (1987) described four symptoms characteristic of all young patients with P.T.S.D.:

- **Visualisation;**
- **Re-enactment;**
- **Fear;**
- **Futurelessness.**

However, Terr (1985) reported that children did not experience psychic numbing or flashbacks, symptoms commonly found in adults, but that they developed a **distorted sense of time** more frequently. This included a **foreshortened view of the future.**

Terr believes that children over 3-4 years **remember their experiences vividly** unlike adults who repress their memories of trauma and often show amnesia for traumatic events. She also observed a **less enduring effect on performance** (school) than in adults. Children **re-enacted trauma** more often than adults and expressed traumatic memories in play.

In contrast to Terr's findings, **Udwin** and others, noted **flashbacks** and **amnesia** in child survivors of the Jupiter sinking (Udwin, 1992).

Frederick (1985) believed that psychic numbing as such was not evident in children, but that they manifested **unique avoidance behaviours** as a form of numbing.

It has been reported that **generally raised levels of anxiety** are common, and that environmental stimuli can trigger **panic attacks** (Udwin, 1992).

Eth and Pynoos (1985), compiled a list of common reactions to trauma in children of all ages, based on their work with 40 children who had witnessed the homicide of a parent and on their observations and review of the literature. This list (Johnson, 1989, p.44) is included in this review because it is considered particularly relevant in this study. The following areas are delineated by Eth and Pynoos as deleteriously affected:

COGNITION

- Recurrent and intrusive recollections;
- Decline in school performance;
- Learning problems;
- Misperception of duration and sequencing.

AFFECT

- Psychic numbing;
- Feelings of detachment;
- Constricted affect;
- Fear of repeated trauma;
- Anxiety;
- Feelings of guilt;
- Pessimistic expectations of the future;
- Intolerance of the fear response.

INTERPERSONAL RELATIONS

BEHAVIOUR

- Inhibited;
- Hypervigilant, avoidant, or phobic;
- Startle reactions;
- Re-enactments; unknowing performance of similar acts;
- Repetitive unsatisfying play involving traumatic themes;
- Counterphobic;
- Nightmares.

VEGETATIVE FUNCTION

SYMPTOM FORMATION, INCLUDING PERSONALITY CHANGE

Significantly, it has been noted that children's responses after trauma may lead to incorrect assumptions about symptoms and post-traumatic criteria can be obscured (Terr, 1987a). For example, **an unresponsive, withdrawn child might be regarded as amnesic for the event.** Parents' and teachers' reports should be included in the assessment of cases so that all symptoms can be elicited. Furthermore, traumatised children appear to present different clinical features, depending on the stage at which they are observed after trauma (Terr, 1993). It has been found that overt manifestations of *reactivity* are often absent immediately after trauma in children (Terr, 1993).

The above account serves to illustrate the **diversity of clinical manifestations of post-traumatic stress disorder which may be found in children.** It is this diversity which tends to frustrate taxonomists intent on establishing child psychiatry as a scientific discipline (Werry, 1992). It also explains the difficulties in the diagnosis of cases, let alone those that are contributed by the factors which follow.

CHAPTER 3:

FACTORS WHICH IMPACT ON THE CLINICAL PRESENTATION OF POST-TRAUMATIC STRESS DISORDER IN CHILDREN.

A number of factors have been implicated in rendering individuals at risk for P.T.S.D. Some of these risk factors make children particularly vulnerable to stress reactions, at the same time influencing the manifestations of P.T.S.D. in them.

3.1. Current explanations of P.T.S.D differ

Presently there are two models which serve to explain the development of post-traumatic stress disorder in adults:

I) The ***stress evaporation model***, and
II) The ***residual stress model***.

The *stress evaporation model* assumes that P.T.S.D. is rooted in individual psycho-pathology. It postulates that stress reactions disappear quickly unless the individual is pathological. In contrast, *the residual stress model* emphasises the degree and nature of stress in the development of symptoms, as the primary etiological factor (Foy, 1987).

These contrasting models have implications for the factors that are considered as being significant in the psychopathology of young people after stress.

In children the evidence is accumulating that a **number of factors** are involved in the development of post-traumatic stress disorder (Anthony, 1986; Udwin, 1992). **These factors interact** and impact on the presentation of symptoms, contributing to difficulties in the diagnosis of individual cases.

The following factors have been emphasised in the literature:

3.2. Age and developmental stage.

3.2.1. FINDINGS BASED ON STUDIES BY ETH AND PYNOOS

Eth and Pynoos (1985) describe the following features of post-traumatic stress disorder specific to age:

Pre-school-age children manifest:

- Withdrawal, subdued and mute behaviour;
- Denial;
- Participation in re-enactments and unsatisfying plans involving traumatic themes;

- Anxious attachment behaviours;
- Regression to previous levels of functioning;
- Relatively brief grieving periods;
- Denial of permanence of change.

School-age children show:

- Lowering of intellectual functioning;
- Decline in school performance;
- Inner plans of action (e.g. retribution through fantasy);
- Obsessive talking about the incident;
- Isolation of affect;
- Constant anxious arousal;
- Behavioural alterations;
- Peer relational problems;
- Elaborate re-enactments;
- Psychosomatic complaints.

Adolescents demonstrate:

- Acting-out behaviour (truancy, substance abuse, sexual activity, etc.);
- Premature closure of identity formation;
- Self-criticism;
- Fear of repetition of the event in future.

In general, Eth and Pynoos (1985) draw attention to the **erosion of development** by traumatic anxiety. Progress over developmental lines can be accentuated, retarded or fixated.

3.2.2. SIGNIFICANT AGE-RELATED FINDINGS IN OTHER STUDIES

Under 3-4 years:

Terr (1985) observed that very young children tend to forget their experiences as such, but form **pre-verbal memories** which can be demonstrated in the traumatic imagery of their play and in the mental representation of their fears. The imagery tends to be unique, as the mental representations consist of the child's impressions of the trauma, condensed, reprocessed and symbolically expressed together with non-traumatic mental images. These complex symbols usually require expert interpretation (Terr, 1985).

Pre-school children:

Children in this age group show less global psychological distress than children in older age groups (Block, 1956; Gleser, 1981). However, they show a higher incidence of **specific behavioural disturbance,** including trauma-specific and generalised fears, regressive toileting habits, distractibility and aggressiveness (Burke, 1982).

School-age children:
Symptoms in this group are characteristically **trauma-specific fears and anxieties, somatic concerns, sleep disturbance and school problems** (Blom, 1986; Burke, 1986; Dollinger, 1984; Galante, 1986; Gleser, 1981; Ollendick, 1982; Pynoos, 1987). Traditional P.T.S.D. symptoms have also been found (McFarlane, 1987; Pynoos, 1987; Terr, 1979, 1981).

Adolescent children:
These children have manifested **symtomatology that parallels the P.T.S.D. criteria** as currently defined in D.S.M.-111-R. The post-disaster response for this age group is marked by trauma-specific fears, depression and anxiety symptomatology, belligerence, and a greater incidence of overall emotional disturbance than in the younger age groups. (Dohrenwend, 1981; Gleser, 1981; Handford, 1986; Milgram, 1988; Ollendick, 1982). Adolescents tend to show more sleeplessness, inattentiveness and irritability than latency-aged children (Terr, 1993).

Adolescents have shown **more sophisticated cognitive appraisal** of their traumatic experiences than younger children (Bromet, 1984; Handford, 1986). Their symptomatology and pessimistic expectations may interfere with future plans and relationships (Udwin, 1992).

Summarising the findings on age, it would appear that younger children are limited by their cognitive ability in their experience of trauma, show fewer denial symptoms and display a disorganised traumatic state, which is likely to be strongly affected by the role and reactions of their care-givers. In older children, traditional post-traumatic stress symptoms emerge. These children have a greater understanding of the traumatic experience, are able to appreciate present and future consequences of events and use more sophisticated reactions to ward off reminders of these unpleasant occurrences (Korol, 1991; Schwarz, 1991).

3.3. Gender

Interestingly, gender **differences** have been found in the manifestations of post-traumatic stress. It has been suggested from **post-disaster studies** that boys react more intensely than girls and that their symptoms resolve slowly, whereas girls become symptomatic at a later date (Burke, 1986). Consistent findings have been reported **after sexual abuse** (Kiser, 1988). In both studies girls ultimately manifested more symptoms.

Similar results have been obtained in the follow-up studies on 179 children who were exposed to the Buffalo Creek dam disaster (Green,

1991). **A higher persistent symptom level was demonstrated in latency age and adolescent girls.**

Various hypotheses have been raised to explain these sex differences (Kiser, 1988).

The notion that boys and girls react differently to environmental situations and, in particular, to relationships, has important implications for the presentation of post-traumatic stress disorder in each sex. In this regard some disturbing observations have been made about the symptomatology of **post-traumatic stress in children who witnessed violent sexual assaults on their mothers** (Pynoos, 1988). Girls had repeated dreams of being attacked and became afraid of strangers or of being in their own neighbourhoods, while some **boys showed signs of identifying with the rapist** rather than with their helpless mothers. In their dreams and play they became the male attacker. It has been suggested by Pynoos that differences in responding to traumatic helplessness may explain why girls tend to appear more depressed and fearful, whereas boys are more likely to show disturbances in conduct.

3.4. Other characteristics of the child victim

Some authors have claimed that children's reactions to trauma are a function of their psycho-biological vulnerabilities. The following suggestions have been made:

There is a **familial predisposition** for developing post-traumatic stress disorder (Solomon, 1988; Breslau, 1991);
***Nervous* children are more prone** to developing psychiatric symptoms (Mercier, 1942; Brander, 1943);
Predisposition to anxiety is more likely to be followed by the post-traumatic stress response than predisposition to psychosis (Anthony, 1986);
Neurologically-impaired children are more vulnerable to the impact of traumatic stress (Green, 1985; Lewis, 1989);
Pre-existing psychiatric illness places a child at higher risk for P.T.S.D. (Pynoos, 1985a; Rutter, 1985; Earls, 1988; Martini, 1990);
Aggressive children are more likely to be exposed to extreme violence (Lewis, 1979; Cicchetti, 1989) and are at high risk for traumatic stress;
Innate capacities of intelligence, humour and relatedness are protective Garmezy, 1987).

As an explanation for individual differences, it has been suggested that in certain cases, **personality organisation** and its **neurological substrate** is such that experiences can become rooted as psycho-biological configurations, which are termed **malignant memories** (Schwarz, 1991).

These "toxic" configurations may continue to distort the cognitive, affectual and social functioning of the individual in a particular way.

An example of the influence of a child's personality characteristics on symptomatology has been observed in aggressive children. It has been found that **in violent young people paranoid ideation and misperceptions feature prominently.** However, these symptoms are analogous to the hyper-vigilance of abused children and animals, and may be secondary to abusive treatment, rather than character pathology (Lewis, 1992). **Aggressive, abused children also manifest lack of empathy towards others** for which Lewis has proposed a psycho-biological stress mediated mechanism rather than personality deviance. Nevertheless, this author is of the opinion that psycho-biological vulnerability makes certain children **more susceptible than others to stress effects** in that they are more **irritable and impulsive** after stress. She believes that their hyper-vigilance, paranoia, impaired judgement and lack of verbal competence and empathy can be attributed to these effects. In support of stress-mediated views of aggressive behaviour, it has been shown that **stressful events can alter brain chemistry and induce aggression** (Eichelman, 1992).

Another example of the effect of personality style on presentation is the **tendency to somatize** in some children. Amongst the typical post-traumatic behaviours in pre-school children are **psychosomatic complaints** such as stomach-ache, headache and digestive upset (Johnson, 1989). Older children may present with a **conversion disorder** as a manifestation of their distress (Goodwin, 1979; Gross, 1979). It is not clear whether the tendency to somatize represents **psycho-biological vulnerability** of the child or is a **function of the situation.** It may be a way of attracting attention in a particular environment (Johnson, 1989) or a dissociative protective mechanism to escape intolerable feelings in extended periods of stress (Terr, 1991).

Summing up current views on psycho-biological vulnerability and P.T.S.D. in children, it seems that there are many unresolved issues in this area, which are still to be researched (Garmezy, 1986; Anthony, 1986) and that sophisticated methods are required to provide answers. It is not yet clear whether stress-sensitivity or resilience in children is related to make-up and how post-traumatic symptomatology is affected by psycho-biological vulnerability.

3.5. Parental reactions and psychopathology

Parental reactions strongly influence the presentation of post-traumatic stress disorder, particularly in the very young (Green, 1991). This is due to the immense importance of the parents as a *protective shield* to the child (Freud, 1920).

In a large study of psychiatric reports after the Buffalo Creek dam disaster, Green has demonstrated that the **disorganised post-traumatic state** manifested by young children was likely to be influenced by parental reactions to the event and by their interactions with the children subsequently. **Adolescents also tended to be affected by parental responses** that were unsupportive towards their younger sibs, presumably because they had to bear the brunt of care-giving if parents functioned poorly. The adolescents shared their parents' **survivor guilt** and effectual responses, **girls showing more anxiety and depressive symptoms**. There is reason to believe that the child's identification with the same sex parent is the likely explanation for these findings (Pynoos, 1988).

Studies of P.T.S.D. presentation in other situations have demonstrated how a child's **symptomatology can be influenced when the parent(s) is a victim of an attack**. For example, in a study on children who witnessed sexual assault of their mothers (Pynoos, 1988), it was found that children behaved differently towards their parents and family members after the event. **Ambivalent and protective attitudes** were noted towards mothers. In one case a boy feared contamination by his mother. In other cases, **anger was expressed towards the parent** who, in the child's experience of the situation, had been ineffectual in preventing the trauma.

With regard to parental psychopathology and the manifestations of P.T.S.D. in children, it would appear that **physical and/or sexual abuse by sadistic and/or psychotic parents can be profoundly damaging** (Goodwin, 1985; Anthony, 1986).
Although the particular features of P.T.S.D. which characterise these cases have not been defined, their association with **multiple personality disorder** in adulthood is by now well documented (Putnam, 1984;Wilbur, 1984).
It is likely that children who are traumatised in this brutal way by their caregivers use **various defense mechanisms** to serve their adaptive needs. It has been proposed that self-hypnosis, dissociation, fugues, psychogenic amnesia and escape into fantasy are some of the mechanisms used (Ross, 1991).
However, as there may be a **genetic vulnerability to hypnotizability and dissociative disorder** (Putnam, 1991), these manifestations of P.T.S.D. cannot simply be ascribed to the disorganising effects of sadistic assaults by disordered parents. Furthermore, information is accumulating about the impact of violent parental interactions on the child's attitude to resolving conflict.
It appears that the **witnessing of parental violence** does influence a child in the direction of **inappropriate ways of resolving conflict**. Children who are chronically exposed to such circumstances are also at risk for **anxiety, depression and other psychopathology** (Kashani, 1992).

There has been considerable interest in the post-traumatic manifestations of children who are *snatched* or **kidnapped** by their own parents (Schetky, 1983; Senior, 1982; Terr, 1983c). Children who are snatched by a parent are often *brainwashed* by that parent, suffer grief for the absent parent and rage at one or both parents. **Exaggerated identification** with the snatching parent may occur. Most children who have been kidnapped by a parent demonstrate signs of psychic trauma.

The **relationship between the child-victim and perpetrator of abuse** as a factor in the manifestation of P.T.S.D. in childhood has been the focus of a number of studies (Schultz, 1983). In a study of sexually-abused children, it was found that **75% of children abused by their natural fathers suffer from P.T.S.D.** (McLeer, 1988).
While the above parental characteristics and the fact that parents are, in some cases, the perpetrators of trauma might increase the risk of P.T.S.D. in a child, the circumstances in such cases are often such that other factors could be implicated as crucial in the development of the disorder, e.g. family functioning, chronicity and nature of abuse, etc.

3.6. Family functioning

In addition to parental functioning, **family dynamics** have been emphasised as significant factors in the development of P.T.S.D in children (MacLean, 1980; Benedek, 1985). Many researchers have found that the family is the strongest potential support for the sexually-abused child with P.T.S.D. When families have been significantly affected by trauma or their functioning is severely impaired for other reasons, the child may manifest **symptoms reflecting the intra-familial psycho-dynamics or psychopathology.** For example, the appearance of a person in the form of an **hallucination** in a child may indicate the family/system need for the reassuring presence of that person (Yates, 1988). Similarly, symptoms have served as **metaphors** for family issues, e.g. *happy family* games have reflected a children's attempts to restore a comfortable family atmosphere after trauma.

3.7. Community and group dynamics

In some studies, certain post-traumatic symptoms have been reported to spread quickly from child to child, affecting untraumatised siblings, family members and also the community at large (Terr, 1985). In this regard, post-traumatic play, visual and time distortions, such as *ghosts* and *omens*, appear to be especially *contagious* (Terr, 1987a). Terr believes that this **contagion** accounts for common rituals which develop in communities, e.g. Ring Around Rosie, a game played after the Black Plague and which is still popular in 20th Century nursery schools.

Furthermore, it has been observed that **vicarious traumatisation** of children occurs when certain contemporary anxieties, e.g. threat of nuclear war, spread through group communication (Beardslee, 1982; Schwebel, 1981).

The contagious effects of stress symptomatology in children may not be immediately apparent after a stressful event in the community, but **might surface later.** After a kidnapping experience in Chowchilla, symptoms appeared later in children through group communication that were not present initially (Terr, 1983a). It has been suggested that some of these symptoms could have been transmitted in certain children, because the *soil* was *receptive* and the **symptom expressed a universal concern.** Some symptoms could not be assimilated, because they were elaborate and too personally derived. **Fears, omens and misperceptions appeared to be easily transmitted,** whereas a complex visual hallucination was not.

Interestingly, the response of children traumatised in small groups was to direct their post-traumatic play out of the group. They played secretly with non-traumatised peers rather than with co-victims (Terr, 1981; Green, 1985). The **tendency for individuals traumatised in groups to avoid associating with one another,** has also been found in adults (Green, 1985). It has been suggested that this behaviour reflects difficulty in finding solace from others who have been similarly emotionally overwhelmed.

There have been some studies reporting the **transmission of symptoms**, e.g. survivor guilt, from generation to generation (Borocas, 1973). However, these studies on concentration camp survivors have been criticised for poor methodology (Solkoff, 1981, 1992).

Children may be particularly susceptible to the **assimilation of post-traumatic symptoms** in a disorganised environment. Where communities have been affected by collective trauma, degrees of post-traumatic stress disorder can be found in victims, onlookers, rescue workers and clinicians. Following the Buffalo Creek flood, most of the 234 children interviewed had been significantly impaired emotionally by the experience (Newman, 1976). Besides **post-traumatic stress symptoms**, they manifested peculiar **distortions in their apperception** of the destructive environment, viewing it as cradling and sustaining. An intriguing finding has been the **increase in creative activity** in some children following group trauma. It has been suggested that this activity represents an attempt by children to meld their reactions and observations into a meaningful whole when the environment is threatening (Anthony, 1986).

It has been **difficult to evaluate the various factors** which impact on children's post-traumatic reactions when communities are destabilised, as there are so many **mitigating or aggravating circumstances,** e.g.

availability of help, presence or absence of parental support, the intactness of the family and the solidarity of the community (Anthony, 1986).

In South Africa and elsewhere the **manifestations of P.T.S.D.** have been observed in children in communities destabilised by **political violence** (Straker, 1990; Dawes, 1990; Allodi, 1980; Cohn, 1980; Ayalon, 1983; Arroyo, 1985). The findings have not been uniform and appear to reflect the above-mentioned factors and others on the various aspects of a child's presentation. Moreover, it has been pointed out that children can be affected in subtle ways which involve their **moral and political socialisation** (Coles, 1986). The findings in the South African studies indicate that the sequelae of political violence in communities are not limited to post-traumatic stress symptoms and that the behaviour of children in these situations can vary from **aggressive acting out** (Swartz, 1986) and **fascination with violence** (Gibson, 1990) to **withdrawal,** cautious reflection and even the **expression of forgiveness** towards the perpetrators of violence in the community (Dawes, 1990).

In summary, the contagious effects of post-traumatic symptomatology in communities and groups have been described in children. It appears that children in destabilised communities may be particularly susceptible to these effects. However, it has also been observed that **a child's unique perception of events can only be understood in terms of an interactive process.** It is therefore difficult to implicate community dynamics in any specific way in the presentation of symptoms. Moreover, the variation and complexity of presentations in disorganised circumstances make the diagnosis of P.T.S.D. particularly problematic in such collective settings.

3.8. Cultural factors

Although cultural factors have not as yet been implicated in the presentation of P.T.S.D. in children, it is possible that symptomatology may be affected by these factors, as has been found in adults (Kroll, 1989). A study in Cambodian refugee children has demonstrated a high prevalence of depressive symptoms (Sack, 1986), but this symptomology may be due to factors other than cultural characteristics.

3.9. Nature of the incident/stressor

Several authors have drawn attention to the **nature of the stressor** in the development of Post-Traumatic Stress Disorder.

It has been suggested by prominent investigators in the field that the child's response to trauma is a function of the **specific characteristics of the victim and the incident** (Benedek, 1985; Malmquist, 1986; Kiser, 1988).

Post-Traumatic Stress Disorder in children has been studied in the following trauma-specific situations:

Natural disasters (Lacey, 1972; Newman, 1976; Yule, 1990),
Human-induced disasters (Terr, 1981; Frederick, 1985),
Kidnapping (Terr, 1979),
Child-snatching by parents (Terr, 1983),
Civil warfare (Arroyo, 1985),
Terrorism (Ayalon, 1983),
Detention (Straker, 1990),
Witnessing acts of violence (Pynoos, 1985),
Child abuse (Green, 1985),
Incest (Goodwin, 1985),
Dog-bite (Gislason, 1982),
Cancer treatment (Nir, 1985),
Mutilating surgery (Earle, 1979),
Accidents (Martini, 1990).

With regard to the childhood manifestations of Post-Traumatic Stress Disorder, it would appear that whether they originate in violence, bereavement, uprooting, natural or man-made disaster, or conditions of war, the **presenting features** have a great deal **in common**. However, there are some **distinctive manifestations** that relate to **particular stressors** and some experiences have consistently emerged as **more traumatic** than others. Consequently, it has been suggested that it may be necessary to develop a **nosological spectrum** of stress-trauma disorders to accommodate the specific effects of some stressors, e.g. incest, child-battering and sexual abuse (Terr, 1987a).

In a recent review Mc Nally (in press) has concluded that exposure to **violence** was **more likely** to produce P.T.S.D. in children than were other types of trauma (Green, 1991).

3.10. Characteristics of the incident/stressor

3.10.1. EXPOSURE TO VIOLENCE

The recognition that P.T.S.D. is more severe and longer lasting when the stressor is of ***human design*** has extended from adults to children (Pynoos, 1985b).

Human-induced violence has particularly traumatic effects (Frederick, 1980). In such cases, besides the post-traumatic symptomatology, Pynoos describes a dominance of **rescue fantasies by third party intervention and the child may identify with third party actions** e.g. the police, paramedics, doctors, judges, jailers. In this way the child attempts to prevent further violence, undo injuries or mete out punishment. Where a parent is involved in the violence, intervention fantasies may serve to perpetuate **post-traumatic guilt** connected to imagined failure to intervene (Pynoos, 1988) which the child may feel because he/she has not intervened.

Violent acts by adults challenge a child's trust in adult restraint (Black, 1988). **Revenge fantasies or identification with the aggressor** can also cause a child to lose confidence in his/her own ability to control impulses. Uncharacteristic reckless, aggressive, self-destructive behaviour or prominent inhibitions make their appearance. **Unconscious re-enactment of violence** can endanger the child and others.

Some child-witnesses to violence are actually drawn to **thrill-seeking** as a way of reassuring themselves that the fear of danger can be tolerated (Pynoos, 1985b).

Generally the viewing of violent acts by caregivers causes **profound changes in the child's sense of security** and faith in intimate human relationships (Pynoos, 1985b).

3.10.2. INTERACTION OF TRAUMA AND GRIEF

When trauma is associated with grief, **feelings of loss** often predominate and grief reactions with the familiar sequence of protest, despair and detachment (Bowlby, 1973) may obscure P.T.S.D. symptoms.

Some authors maintain that **a parent's death usually constitutes massive psychic trauma** in a child and that the immature ego sometimes becomes overwhelmed in the grief process (Black, 1978; Krueger, 1983).

Bereavement *per se* has many features and often causes regression in vulnerable children. In some situations involving bereavement the cognitive abilities of the child are lost and infantile anxieties are reactivated, so that the child becomes preoccupied with security. This preoccupation may cause a grief-stricken child to **distort reality** so as to maintain contact with a caregiver. In these cases, **hallucinations**, particularly of the deceased, have been linked with bereavement, the symptom allowing the child to vicariously re-establish a closer bond with the caregiver (Yates, 1988). Such a child is often described as ***haunted*** by ghosts.

The symptoms in young, bereaved children can be perpetuated owing to their **cognitive limitations,** in that they may not understand the finality of death (Baker, 1992).

As the presentation of bereaved children often involves ***psychotic*** features, these can overlap with the features of P.T.S.D. (Baker, 1992).

When grief and trauma interact, e.g. **witnessing the violent death of a parent, the psychic trauma is intense.** Symptoms reflect this intensity. Expressions of **extreme anxiety** mingle with other manifestations of distress to create a highly confusing picture for the clinician (Eth, 1985).

A review of the reactions of young children to the violent death of a parent indicated that the children were diagnosed as **having over-anxious disorders, dysthymic disorders and conduct disorders** (Payton, 1988). It was the impression of the authors that these disorders complicated the resolution of traumatic loss, as they affected the current caregivers feelings towards the problematic children.

3.10.3. CHILD ABUSE

Studies of the manifestations of P.T.S.D. after childhood physical and sexual abuse present particular difficulties in interpretation because the trauma has occurred over long periods and is associated with **other disadvantages for the child** (Green, 1983; Estroff, 1984; Cicchetti, 1989; Oliver, 1988; Widom, 1989). In particular, the psychosocial development of abused children is affected in a number of ways which makes them vulnerable to stress (Wissow, 1990).

There have been numerous studies in this area and the following conclusions provide some guidelines on the presentations in physically abused children.

Physically abused children

Physically abused children typically display features of the **Child Abuse Syndrome**, which tend to overlap with those of P.T.S.D. The components of the syndrome comprise **two categories of trauma**, the **acute physical assaults** and the **psychological effects** of those assaults within the context of pathological child-rearing in multi-problem families (Green, 1983). Green has stated that most of the abused children in his treatment program satisfied the criteria for P.T.S.D., but that they also displayed a wide variety of other psychiatric diagnoses. These included **Conduct Disorder, Anxiety Disorder, Dysthymic Disorder and Specific Developmental Disorder.**

Green and others have found a **high incidence of central nervous impairment in abused children** who had no evidence of head trauma (Green, 1981; Sandrund, 1974).

Protective symptoms, which have been associated with the Child Abuse Syndrome are the following:

- Avoidance of eye contact in infants and toddlers;
- *Frozen watchfulness* in others (Ounsted, 1974);
- Avoidance and distancing behaviour;
- Denial of pain and constriction of affect;
- Identification with the aggressor.

Some children manifest **provocative self-defeating, pain-seeking behaviour** and provoke beatings. It is thought that this behaviour represents an attempt by the child to attain mastery over predicted abuse, because the child fears being taken by surprise (Green, 1983).

It has been observed that these children are often **scapegoated** and blamed for the inadequacy of their parents or siblings (Green, 1983).

Another important observation in physically abused children is that **post-traumatic play may intensify their anxiety** instead of resolving it (Green, 1985; Terr, 1981). It is believed that the child's identifications with the violent aggressor in fantasy are too frightening to the undefended child.
At times a full-blown ***traumatic neurosis*** is described with the development of a panic state, psychotic disorganisation, psychosomatic symptoms or depressive withdrawal.

Sexually abused children

Studies on the impact of sexual abuse have indicated that **46-66%** of sexually abused children demonstrated **significant and severe symptoms** (Browne, 1986). These symptoms are mainly related to anxiety and its associated manifestations of autonomic arousal, avoidant behaviours and re-experiencing phenomena. These symptoms are reported by a number of authors and constitute partial criteria for P.T.S.D. (Wolfe, 1989).

Adams-Tucker (1982) found symptoms in all cases of sexually abused children who had been referred for psychiatric care and reported the following prominent symptoms:

- Sleep disturbances;
- Anxiety;
- Withdrawal;
- Psychosomatic symptoms;
- Depression;
- School difficulties;
- Various behavioural problems.

Although many psychiatrically referred sexually abused children meet the criteria for P.T.S.D. (McLeer, 1988), there is some controversy about whether it is the abuse experience and its intensity or its persistent nature which is traumatising.

A recent study indicates that children and adolescents reacting to **single event abuse displayed more behavioural disorders**, whereas victims of ongoing abuse appeared significantly more disturbed with symptoms ranging from depression to psychosis (Kiser, 1991).

McLeer found that **P.T.S.D. is more common in children abused by parents, adult care-givers, or adult strangers than in children abused by another child** (McLeer, 1988).

Goodwin (1985) has reported P.T.S.D. in most of the child incest victims referred for treatment, but drew attention to the fact that the symptoms were difficult to recognise due to the victim's young age, and the child's **tendency to conceal both the symptoms and the abuse.**

Sexually abused children's attempts to adapt to abuse by their caregivers have often confounded clinical diagnoses, giving rise to the use of the term *accommodation syndrome* to describe the children's behaviour (Summit, 1983).

Goodwin observed that the symptom pattern in childhood incest victims was similar to that seen in adult rape victims (Burgess, 1974), namely, **fear, sleep and eating disturbances, guilt, decreased functioning, sexual problems and irritability.** However, it was noted that the symptoms were more numerous, more severe and longer-lasting in childhood incest victims. Mrazek (1980) recorded the following symptoms in a review of child and adolescent incest victims:

- Fears;
- Anxiety;
- Sleep disturbances;
- Depression;
- Low self esteem;
- Guilt;
- Psychosomatic problems;
- Sexual disorders of all types;
- Behaviour problems.

As there are so many overlapping symptoms between children's response to trauma and their reactions to abuse, the question has arisen whether the symptoms should be regarded as P.T.S.D. or the Child Abuse Syndrome (Kiser, 1991). However, most investigators agree that detailed descriptions of presentations in sexual abuse have provided the core criteria of Post-traumatic Stress Disorder. The P.T.S.D symptoms may be modified by specific individual experiences.

The following examples are illustrative:

- **Fears** may reflect aspects of the experience, e.g. the fear of red lipstick (Kiser, 1988), moustaches (Wissow, 1990);

- Fear of disclosing the abuse might result in **conversion symptoms, e.g. elective mutism** or psychogenic blindness (Nospitz, 1987);

- **Re-enactments** include:

    - Kissing,
    - Simulating intercourse,
    - Self-mutilation,
    - Provocative movements,
    - Pseudo seizures,
    - Display of sexual knowledge (Nospitz, 1987);

- **Guilt** may cause the child to adopt a *Cinderella* position in the home (Nospitz, 1987);

- **Self-mutilation** may represent excessive control over unruly emotions associated with the abuse (Cross, 1993).

A number of authors have drawn attention to the importance of eliciting the symptoms which might otherwise remain hidden in sexually abused children.

3.10.4. CO-EXISTENCE OF OTHER PSYCHIATRIC DISORDERS

It has been recognised that P.T.S.D. can co-exist with other psychiatric disorders, e.g. depression, adjustment disorder, phobic disorder, etc. (Udwin, 1993). In particular, children who suffer maltreatment may exhibit the criteria of a number of disorders, including psychosis. The presence of these disorders (Famularo, 1992) is likely to create a bewildering and disturbing picture for the clinician.

CHAPTER 4:

NEWER CONCEPTS OF CHILDHOOD TRAUMA AND THEIR IMPACT ON THE DIAGNOSIS OF POST-TRAUMATIC STRESS DISORDER

The current literature on P.T.S.D. indicates that a distinction can be made between reactions to trauma after exposure to a single traumatic event and those which follow repeated traumatic experiences.

Terms that describe the effect of long-standing situations such as *strain-trauma* (Kris, 1956), *cumulative trauma* (Kahn, 1963), and *continuous traumatic stress* (Straker, 1987) appear to have been absorbed by a theoretical new classification of trauma-related disorders in children (Terr, 1991).

Based on her extensive studies of trauma in children, Terr has expanded the list of diagnostic criteria for P.T.S.D. and presents differential findings for Type I and Type II Post-Traumatic Disorders (1987b).

4.1. Type I, or single-blow traumatic disorders of childhood

These are defined as those following unanticipated single events. Terr states that they are the *most typical* post-traumatic stress disorders in childhood, usually meeting the major criteria in the D.S.M.-111-R. However, certain symptoms and signs differentiate these conditions from those resulting from more complex events. They are as follows:

- **Full detailed etched-in memories;**
- ***Omens;***
- **Visual misperceptions;**
- **Distortions of time perception.**

4.2. Type II disorders of childhood

These disorders follow long-standing or repeated exposure to extreme events such as sexual abuse. In these disorders, Terr describes massive attempts of the child to protect the psyche and preserve the self. She reports massive denial, repression, dissociation, self-anaesthesia, self-hypnosis, identification with the aggressor, aggression turned against self, rage and unremitting sadness. These features occur side by side with fear, which is a constant feature of P.T.S.D. Terr believes that it is the Type II disorders that have a **profound effect on personality development** and which often present to professionals as Conduct Disorders, Attention Deficit Disorder, Depression and Dissociative Disorder.

A recent study of 163 abused children (Kiser, 1991) **supported Terr's conceptualisation of two types of trauma-induced disorder.**

In a South African study of P.T.S.D. in brutalised adolescents who had experienced multiple long-standing traumas, a clinical impression was formed that the emotion experienced was not uniform across all the traumatic events (Straker, 1990). **Experiences of separation, exile and witnessing the death of a loved one** emerged as the three experiences that were **most traumatic** and elicited high levels of insecurity, persecutory anxiety, survivor guilt and flashbacks to the death scene respectively (Straker, 1990).

It was also found that the **meanings and values ascribed** to a particular trauma influenced the emotional experience which followed it. The violent death of an enemy was not necessarily perceived as traumatic.

For many children ongoing trauma involves several different types of traumatic experiences and in these cases each trauma carries its own predicament for the child, just as **each predicament has its own features.** Some of these have already been addressed at some length. In **uprooting and dislocation,** feelings of alienation, persecutory anxiety and homesickness are found. In **bereavement**, feelings of loss predominate manifested by grief reactions.

In the **disaster syndrome,** death anxiety and survivor guilt may predominate. Whatever the trauma, it seems as if the **most disturbing events for a child are those which threaten his/her safety and attachment to others.**

In summary, newer concepts of trauma in children have pointed to the importance of each traumatic event which may have altered a child's sense of security, and to the effects of multiple trauma in the presentation of P.T.S.D. in childhood.

CONCLUSION

In concluding this section of the review, the remarks of James Anthony (1986) are appropriate. He states:

> "From the work to date, it is evident that reactions to overwhelming predicaments are **steeped in closely interacting biological, psychological and social processes."**

From this review it will be obvious that while Post-Traumatic Stress Disorder has specific diagnostic criteria, individual cases may present in very complex ways which are determined by interacting processes. The complexity of presentation in some cases demands alertness on the part of clinicians in order to elicit the diagnostic criteria of P.T.S.D. in the midst of the numerous problems which accompany the diagnosis, some of which are other psychiatric disorders..

CHAPTER 5

COURSE OF POST-TRAUMATIC STRESS DISORDER IN CHILDREN

5.1. Current state of knowledge

The study of traumatic stress has yielded a great deal about symptomatology, but research into the course and outcome of Post-Traumatic Stress Disorder in different situations is still in its infancy.

One of the findings that has emerged is that trauma has **far-reaching effects on people's lives** both in terms of personal impact and of family disturbance (Lyons, 1991).

A number of authors have hinted that childhood trauma, without early intervention, may coalesce into pervasive long-term symptomatology (Eth, 1986; Pynoos, 1984, 1986; Terr, 1983; Udwin, 1993).

Recent observations linking stress and violence with **permanent biological changes** in the organism are disturbing (Eichelman, 1992), as are the suggestions that the neurobiological alterations associated with P.T.S.D. may make affected individuals more susceptible to substance abuse (Friedman, 1991) and Affective Disorder (Olivera, 1991).

No large studies have been done to date, which delineate the natural history of P.T.S.D. in childhood (McLeer, 1992), but in the past seven to ten years more systematic studies have been undertaken (Udwin, 1993).

Most of the studies on the course and outcome of Post-Traumatic Stress Disorder have been in **adult war veterans**, many of whom have been found to be persistently symptomatic or to have chronic adjustment problems in the long term (Foy, 1987; O'Brien, 1991). However, in this group of subjects, delayed or chronic P.T.S.D. is often associated with other psychiatric symptoms and maladaptive coping responses, making the assessment of outcome and evaluation of treatment strategies difficult (Eldridge, 1991).

Studies in children meeting the criteria for Post-Traumatic Stress Disorder, as currently defined in D.S.M-111-R, have only recently been undertaken. Therefore it has not yet been possible to examine the course of the disorder in terms of its long-term outcome. However, a number of observations have been made in children who were exposed to catastrophic experiences and who have later fulfilled the criteria for P.T.S.D.

5.1.1. STUDIES

The following studies have provided useful information on short term findings:

5.1.1.1. Buffalo Creek dam and other disasters

A major breakthrough in documenting children's responses to stress had been made when 234 children were interviewed in depth after this disaster (Newman, 1976).

Subsequently, the psychiatric reports of 179 of the above children were rated for the symptoms of P.T.S.D. (Green, 1991). **Two years after the disaster,** approximately 37% of the children were given a diagnosis of probable Post-Traumatic Stress Disorder. There were fewest symptoms in the youngest age group and higher symptom levels for girls than for boys. Multiple regression analysis showed that life threat, gender, parental psychopathology and disturbed family functioning all contributed to the prediction of P.T.S.D. symptomatology in the children. In particular, the severity of life threat was significantly associated with the **number of P.T.S.D symptoms** 2 years after the trauma. The association of high risk to life and severity of persistent symptoms has been found in a subsequent study involving children (Pynoos, 1987).
Similar findings have been recorded **after a school bus accident**. Milgram (1988) found that 50% of the high exposure group met the criteria for P.T.S.D. one week after the accident and about 20% met these criteria **9 months after** the event. In a large sample of children exposed to **community bush fires,** parents reported P.T.S.D. symptoms in more than 50% of the children 2 months after the fire and in 33% of the children **2 years later** (McFarlane, 1987).

5.1.1.2. The Chowchilla studies

Terr's extensive studies on the children who were exposed to the Chowchilla kidnapping in 1976 have probably been the most helpful in determining the possible long-term effects of a particular type of trauma in children. Interestingly, she found that very early traumatic responses are unusual and that physical and emotional control is often retained. Terr reviewed the reactions of the children 5-13 months after the event and then 4 years later. Among the relatively **long-term effects** she found recurrent dreams of the child's own death, pessimism about the future and fear of further trauma, repetitive monotonous compulsive play that maintained a chronic level of anxiety and personality changes (Terr, 1981).

Terr observed that the children **continued to elaborate experiences**, extending omens, fears and misperceptions and to indulge in repetitive phenomena (Terr, 1983a). She noted also that when interviewed later

children tended to be ashamed of their helplessness during the event and consistently tried to suppress the embarrassing tale of what had happened, even though they could still fully recall it. Many children developed a conviction that they were clairvoyant, which Terr believed were their efforts to maintain some control over the situation.

Attention was drawn to the fact that important post-traumatic manifestations **can appear for the first time relatively late,** as the memory for the traumatic event becomes distorted in a particular way and linked to a specific affect. Terr believes that there is a change in quality of late memories for the traumatic event in children (Terr, 1987a).

On the basis of her studies, Terr suggests that the experience of **overwhelming anxiety is not a potentially toughening experience,** but that it is a significant burden to the child in terms of personality development. In proposing newer theories about childhood psychic trauma she has outlined her views on how different problems are set in motion by trauma and how definable mental conditions arise as a result (Terr, 1991). Her formulation of trauma reactions into two basic types, as described in the previous section has stimulated a particular interest in ongoing traumatic experiences in children and their **malignant effects on personality development.** The responses which Terr has ascribed to Type 11 trauma of denial, numbing, self-hypnosis, dissociation and rage are easily associated with the mental conditions and personality deviance commonly seen in adult psychiatry (Ross, 1991).

Finally, Terr has proposed **4 characteristics** related to childhood trauma that are **persistent** and can be recognised whatever diagnosis the patient eventually receives. These are the following:

- **Visualised and otherwise repeatedly perceived memories of the traumatic event;**
- **Repetitive behaviours;**
- **Trauma-specific fears;**
- **Changed attitudes about people, life and the future.**

5.1.1.3. Studies of sexually-abused children

As there is wide variation in the abusive experience in sexually abused children, the course and outcome have been studied in different situations.

Kiser (1988) studied the course of P.T.S.D in 10 children who had been sexually abused in a day-care setting. Their symptoms lasted well over 1 month with some evident 2 years later. The symptoms reported at follow up were similar to those that have been proposed by Terr for Type II disorders. Many of the children found reminders of their experiences

disturbing and were reluctant to deal with their the alleged trauma. This reaction appeared consistent with the **massive denial which Terr has found with repeated trauma** .Other problems reported were personal-social relationship difficulties and mistrust of people, which had not been present before the abuse. In this study which is ongoing, girls had more symptoms than boys at 1 year follow up. This finding is consistent with other studies on P.T.S.D. in children in which **recurrent or persistent symptoms have been found in girls** (Burke, 1986; Green 1991).

In a study of 31 psychiatrically referred sexually abused children, (McLeer 1988) demonstrated that P.T.S.D. is common; 48.4% of the children meeting the D.S.M.-111-R criteria for the disorder. The average time that had elapsed since the last abusive episode had been 8 months. Significantly, this study demonstrated that unless specific questions were asked by the clinician, the diagnosis may have been missed in these cases. The authors comment that they were not able to report on whether symptoms had persisted or fluctuated in these children, but were concerned about their **apparent chronicity** and their **effects on the cognitive, social and behavioural aspects** of the children's development.

Several writers have considered the child's adaptation to ongoing sexual abuse (Friedrich, 1988; Finkelhor, 1988).

Summit (1983), in his classic paper described the *child sexual abuse accommodation syndrome* in which the child adapts to recurrent abuse by entrapment and accommodation. **Delayed and unconvincing disclosures** and **retracted statements** are typical findings in the follow-up of the sexually abused child (Summit, 1983), as are the emotional coping strategies of **self-blame** and **dissociation** (Mrazek, 1987).

5.1.1.4. Adult survivors of childhood sexual abuse

Several investigators have been interested in the symptoms of adult survivors of childhood sexual abuse. Browne and Finkelhor (1986) demonstrated more symptoms and dysfunction in this group of women than in normal controls. Others noted that some of these symptom clusters fit D.S.M.-111-R criteria for P.T.S.D. and these data suggest that women may have suffered from **unremitting P.T.S.D symptoms for years** after the experience of childhood sexual abuse (Armsworth, 1984; Burgess, 1974; Holmstrom, 1979).

However, the **majority of children** who have been sexually abused suffer from a variety of symptoms and their clinical presentation results from a complex interaction between the variables described in the previous section. These contextual factors do not allow easy distinction between the effects of the abuse itself and those responses which can be attributed to

other factors. Many of these children have post-traumatic stress symptoms but do not meet the full criteria for P.T.S.D. (McLeer, 1988).

While some of the above findings deserve attention, it is not possible from retrospective studies to draw conclusions about outcome of P.T.S.D., where individual cases have not been identified and followed up.

Whereas the **course of rape-trauma** has been studied in adults (Steketee, 1987), the course and outcome of traumatic rape in children is as yet unknown.

5.1.2. P.T.S.D. IN CHILDREN (LONG TERM EFFECTS)

Although long term studies on outcome have only just commenced, there has been a great deal of speculation about long-term effects of P.T.S.D. in children and prominent authors have made observations on outcome on the basis of their experience.

Terr (1991) refers to symptoms that she believes develop into **personality styles** after extended abuse. In the sexual abuse population, these symptoms include substance abuse, suicidal attempts, other acts of self-destructiveness, chronic anger, unstable relationships, dissociation and mistrust with fear of abandonment.

In physically and sexually abused children a number of suggestions about outcome have been made, some of which are as follows:

Green (1985) believes that the **vigilant, frozen, watchful child** becomes the **suspicious, hypersensitive, paranoid adult**. He links violent assaultive behaviour in adulthood with childhood abuse and the use of one of the adaptive responses to danger, viz. **identification with the aggressor**. In fact, the latter response has been observed by others in sexually abused children (Burgess, 1987) and in boys who have witnessed sexual assaults on their mothers (Pynoos, 1987).

5.1.3. STUDIES ON ADULT PERSONALITY DISORDER.

Early observations on the effects of trauma on personality development were made in children who had experienced **dog-bite** in infancy (Gislason, 1982). At follow-up the children had undergone **personality changes some 3 years after** the trauma. They were described as cautious and inhibited.

Currently, there is a fair amount of evidence **linking adult Borderline Personality Disorder and Multiple Personality Disorder** with sexual abuse, in particular, incest in childhood (Wilbur, 1984; Putnam, 1984; Briere, 1988a; Bryer, 1987; Westen, 1990; Ross, 1991). An association

between **eating disorders** and sexual abuse has been reported by a number of authors (Waller, 1991; Palmer, 1990). In **severe drug abusers** over 40% of the women have been found to be incest victims (Nospitz, 1987). Evidence is rapidly accumulating, which confirms the long-held belief that **abused children become abusers** as adults (Burgess, 1987).

With regard to the role of P.T.S.D. in the evolution of these psychiatric disorders, it has been postulated that since fugues amnesia and other defense mechanisms have been observed in post-traumatic states, their association with Multiple Personality Disorder seems understandable (Spiegel, 1984; Ross, 1991).

The study of this interesting association is presently beginning (Putnam, 1991). It has been suggested by Putnam that **Dissociative Disorders** may be relatively common in the general population and that they are related to childhood trauma. Authors have consistently reported fragmentation of the personality as a reaction to trauma (Spiegel, 1986; Claasen, 1993). As it is believed that dissociation is a protective mechanism of the overwhelmed ego (Green, 1985), Dissociative Disorder has been referred to as a *secondary diagnosis* by Goodwin (1985), who emphasises the underlying post-traumatic stress.

With regard to current theories about the **mechanism of personality change** after trauma, it seems that these go beyond Freud's theory of the *stimulus barrier* or *protective shield*, which Freud regarded as an essentially passive barrier effectively reducing stimuli. Presently it is believed that this stimulus barrier is achieved by an active defense mechanism of the ego, which not only deals with external stimuli, but also the internal processes (Green, 1985). Some of these processes may involve biological defense mechanisms which result in pain insensitivity (Terr, 1993).

5.1.4. OTHER REPORTS ON LONG-TERM EFFECTS

Besides the above impact on personality, there have been reports on other **long-term effects on development**. These long-term effects include pessimistic life attitudes, diminished self-esteem and disturbances in interpersonal relationships (Pynoos, 1986). In addition to the characteristics of Type II trauma already described Terr has observed **unremitting sadness** as a feature of long-standing trauma (Terr, 1991).

5.1.5. EFFECTS OF TREATMENT/ENVIRONMENTAL FACTORS

As yet, there have not been enough controlled long-term observations of treatment results to predict preventive effects on the course and sequelae of P.T.S.D. in childhood. However, it is the **belief** of a number of investigators that **treatment has a beneficial effect on outcome,** as do

other interacting environmental factors, which have already been addressed in the previous section and which provide a **protective influence.** With regard to these factors some authors believe that chronic P.T.S.D. reflects a failure of the environment to protect the child after trauma (Goodwin, 1985). Pynoos (1986) developed an **interview technique** for assessing and treating traumatised children, which he believes has a beneficial effect on outcome, although controlled long-term trials on this technique have not yet been conducted. The technique allows the child to explore events associated with overwhelming anxiety in the presence of a supportive adult. Pynoos believes that a child has the desire and capacity to collaborate with an adult after a traumatic event and that the response to the interview is a sense of immediate relief and re-establishment of **human relatedness**.
Other authors have also reported that open discussion of the trauma provides **relief** and not distress to the child (Ayalon, 1983; Frederick, 1985). It has been the impression of some authors that **abreaction** is an essential element of treatment and that absence of such an intervention might prevent long-term adjustment.

Adult investigators have suggested that there is an **optimum time** to provide intervention beyond which it is more difficult to achieve ego restoration (Van Der Kolk, 1984).

A report on a unique 10-year follow-up of early intervention in children who had been exposed to parental killing in terrorist activities, has described the experiences of the authors with regard to intervention strategies and outcome (Dreman, 1990). The **techniques** which were mainly of a **cognitive-educative nature did not prevent psychopathology** due to unresolved trauma in the long-term.

Interestingly, Terr found in the Chowchilla study that the majority of children **continued to suffer** from P.T.S.D. despite the provision of **crisis intervention.**

The effect of **group work** in the outcome of P.T.S.D. in children is still to be evaluated. As investigators have reported both positive and negative effects of the **group experience** in P.T.S.D. (Terr, 1985; Kiser, 1988; McFarlane, 1989; Udwin, 1993). The supportive aspects of the group experience cannot be assumed in these cases, as individuals who have experienced trauma such as sexual abuse have different needs (Gottlieb, 1981). However, it is believed that traumatised children need to feel that they are not the only ones who have experienced severe trauma (Terr, 1993).

There is very little information on the **effects of pharmacotherapy** on Post-Traumatic Stress Disorder in children. With regard to the dissociative aspects of trauma reactions, medication as adjunctive treatment has been less effective in children than in adults (Putnam, 1992). Clonidine has been suggested to reduce arousal symptoms, and Propranalol reported to relieve some of the symptoms when used in divided doses (Terr, 1993). Pharmacotherapy in adults with P.T.S.D. has been used by some clinicians (Van der Kolk, 1987) and reported to alleviate intrusive recollections and hyperarousal, but not avoidant symptoms (Friedman, 1989).

In adults tricyclic antidepressants have proved beneficial and help with disturbed sleep. It has been suggested that in chronic P.T.S.D. a minimum of two month's treatment is required to achieve a beneficial effect which exceeds that of placebo (Davidson, 1992). There may be some merit in the use of tricyclics in strongly phobic or depressive children (Terr, 1993).

Current opinion about outcome of P.T.S.D. in children is sufficiently pessimistic that **all treatment options need to be fully explored (**Udwin, 1993**).** In this regard McLeer states:

> "*P.T.S.D. is a serious psychiatric disorder fuelled both by psychological and biological factors with the full blown disorder being resistant to many treatments currently being utilised in many child sexual abuse programs*" (McLeer, 1992).

In **support of the use of pharmacotherapy** in P.T.S.D., both Van der Kolk (1987) and Friedman (1988) have independently suggested that **kindling** is a neurobiological model that may be applicable to P.T.S.D. It is proposed that certain neurobiological structures especially those in the limbic system become increasingly sensitised following repeated stimulation by sympathetic arousal, mediated by the *locus ceruleus* and that a stable neurobiological abnormality is eventually produced by this kindling mechanism.

On this basis treatment with an **anti-kindling drug, e.g. Carbamazepine** has been suggested in this disorder.

Disturbing possibilities have recently been postulated of *addiction* to internal endorphans in P.T.S.D., as an explanation for pain insensitivity and self-mutilation. These possibilities have other implications for future treatment (Terr, 1993).

5.1.6. A DYNAMIC VIEW OF OUTCOME

"*Post-Traumatic adjustment is a dynamic process*" (Dreman, 1990).

As a crisis situation places demands on the family and the child's ability to communicate needs, normal patterns of interaction may be disrupted, creating a post-trauma reaction cycle. A frequency study has shown a correlation between childhood trauma and **maladaptive adolescent behaviour** on the basis of parental reactions (Johnson, 1989). In his book, ***Trauma in the Lives of Children***, Kendall Johnson introduces various crisis and stress management techniques for counsellors and other professionals to address the problems created by the post-traumatic reaction cycle in families and schools, by the young trauma victim.

In this regard the research which highlighted the protective factors in a child's personality and environment has been important (Rutter, 1985; Garmezy, 1987).

Currently there is an emphasis in research on the dynamic processes which are set up by trauma in children's lives. Criticism of the Post-Traumatic Stress Disorder model has been that it draws attention away from these processes and focuses too heavily on symptomatology (Finkelhor, 1985, 1988; Friedrich, 1987; Collings, 1993). In Terr's view researchers should not be trapped into *enlarging the finer diagnostic points of trauma into such prominence that we altogether lose the central point* (Terr, 1991).

5.1.7. CONCLUSION

In concluding the review it should be stated that the points made by prominent authors about excessive preoccupation with symptomatology, have been noted.

Accordingly, in describing the presentations and courses of the cases in the study, the need to maintain an awareness of dynamic processes will be observed.

PART II

CHAPTER 1: CASE STUDY

The case study in **Part 2** of this dissertation will describe the presentation and course of Post-Traumatic Stress Disorder in a group of 6 sexually-abused children who were residing at a children's home in one of the black townships of Cape Town. The purpose of the study has been outlined in the introduction.

1.1. Method

1.1.1. SUBJECTS

The subjects in this study are a group of six children, ranging from 9 to 16 years old. They are all black, Xhosa-speaking females from the lowest socio-economic group. Five of the children were residing at a children's home in a black urban community at the time of presentation. One child was placed at the same children's home within a week of presentation.

1.1.2. REFERRAL

Case 1 was referred to me at the Child and Family Unit, Red Cross Children's Hospital, by the social worker who had placed her at the children's home.

Cases 2, 3 and 6 were presented to me by the superintendent and staff of the children's home, where periodic consultation meetings are held to discuss problems relating to the children and their management.

Case 4 required emergency psychiatric treatment in the overnight ward at Red Cross Children's Hospital and was referred to me on this account.

Case 5 was referred by the resident medical attendant of the casualty department at Groote Schuur Hospital, where she had been taken by the staff of children's home for treatment of venereal disease.

1.1.3. PROCEDURE

Each child in the study was **interviewed within a week** of presentation at the Child and Family Unit, Red Cross Children's Hospital. The interviews were conducted by myself in my consulting room **with the assistance of a Xhosa-speaking interpreter.**

Background information about the children was supplied by the social agencies involved with the placement of the children and by the superintendent of the children's home. Information pertaining to the

behaviour and functioning of the children at the home and at school was obtained from the superintendent and careworkers' and teachers' reports.

In Cases 1 and 4, **the children's mothers were interviewed** within a week of their presentation at the hospital.

In Case 2 an interview with the child's mother was held one month after the subject's admission to the child psychiatric in-patient ward at the Child and Family Unit (she had recently been released from prison and was brought to the unit to visit the child at my request.) In the **other cases it was not possible to interview members of the family**, as they lived in the Ciskei and/or Transkei.

In Case 3 the child's aunt, who lived in Cape Town and who was fostering the child at the time of her admission to the children's home, indicated her **unwillingness** to be involved any further with the child's problems and was not interviewed.

As three of the children were **admitted to the psychiatric in-patient ward** of the Child and Family Unit, the data in these cases includes clinical material from the medical records, charts and therapy sessions.

The follow-up of the cases has been undertaken by myself and is **an on-going procedure**. The longest recorded follow-up is three years (Case 2), and the shortest, one and a half years (Case 6). Follow-up has been largely by way of **telephonic contact and meetings with the staff** of the children's home. In addition, in Cases 3 and 5 follow-up reports were obtained from the **children's therapists or their notes.** As Cases 1 and 2 are no longer residing at the children's home, their progress has been monitored by **social workers** with whom I have maintained contact.

In Cases 1 and 2 **follow-up interviews** were conducted with the patients themselves. However these interviews proved **unsatisfactory,** as it was felt that the children were deliberately suppressing symptoms in case these reflected badly on their behaviour and thus might affect their chances of returning to their families. The follow-up interviews with the children were therefore abandoned, but their **caregivers were asked specific questions** relating to their post-traumatic adjustment.

The confidential records of the cases have been filed at the Child and Family Unit, Red Cross Children's Hospital.

Pseudonyms have been used to protect the identity of the children and the children's home, where some of the children are still residing. However, the cases may be traced by matching the children's birth dates and dates of

admission to the unit, as an admission register is kept at the Child and Family Unit.

1.1.4. INSTRUMENTS

The **interviews** with the children and informants were unstructured and information was accepted at face value.

A **P.T.S.D. symptom checklist** was used to record the symptoms presented for accurate diagnosis of Post-Traumatic Stress Disorder. The checklist contains 3 categories of symptoms according to D.S.M.-111-R criteria for P.T.S.D. (Appendix 1). This checklist has been used in other studies for identifying cases of P.T.S.D. in sexually abused children (McLeer, 1988, 1992).

On the basis of data provided by interviews and reports, **symptoms of P.T.S.D. were recorded as being either present or absent.** In order to fulfil **D.S.M.-111-R criteria** for P.T.S.D., a child had to concurrently manifest at least one symptom of re-experiencing behaviour, three or more symptoms of avoidant behaviours and two or more symptoms of autonomic hyperarousal.

In order to determine the severity of their P.T.S.D., semi-structured interviews with the children were attempted with a view to using the **Post-Traumatic Stress Reaction Index Scale** to score the children's symptoms (Pynoos, 1988) (Appendix 2). A score could be obtained in two of the children, but in the others the interviews were abandoned because of difficulty in communication, particularly with regard to the rating of symptoms.

In an effort to objectify the subjects' overall severity of disturbance of functioning at presentation and follow-up, the **Children's Global Assessment Scale (C.G.A.S.)** was used (Shaffer, 1983) (Appendix 4). This assessment scale allowed the assimilation and synthesis of information collected from the various sources so that it would reflect a single meaningful index of disturbance for clear documentation of initial disturbance and outcome.

With a view to facilitating future examination of the cases, an attempt was made to **define the characteristics of the stressors** in terms of variables which have been used in other studies on abused children (Kiser, 1991). However, as abuse was only one of the stressors experienced by 4 of the children, the trauma and abuse variables chart includes not only the standard variables for abuse, but also the characteristics of the other major stressor, i.e. the witnessing of violence (Appendix 3). The latter stressor has been charted so as to reflect the relationship of the perpetrator of violence to the victim, and any loss or threat to the child's personal safety.

In this study, **intervention strategies have varied** and will simply be recorded in the description of each child's course and in Appendix 6.

1.1.5. BIBLIOGRAPHY

The references have been listed according to the present style recommended by the editor of the British Journal of Psychiatry for that journal (May, 1993).

CHAPTER 2: CASE DESCRIPTIONS

2.1. CASE 1: "RACHEL"

"Rachel" aged 9 years
Date of birth: 19.03.80
Date of presentation at the Child & Family Unit: 17.03.89

2.1.1. PRESENTING HISTORY

Rachel was removed from her parents' home by court order on 18/03/88 when it was discovered that she had been subjected to long-standing violent sexual abuse by her father. A physical examination confirmed that violent sexual abuse had occurred when Rachel presented at the Red Cross Children's Hospital in 1987. Poor appetite, weight loss, withdrawal, apathy, an abnormal sleep pattern with excessive sleepiness during the day and a bloody vaginal discharge was recorded.

Two months after removal from her home, Rachel wrote a letter from the Place of Safety to the social worker, for the first time revealing her father as the perpetrator of the abuse and claiming that he was continuing to abuse her.

Translated extract from Rachel's letter:

"I am not happy. They are killing me. At home they refuse to let me go to school. The one who is ill-treating me is my father. He is doing 'dirty' things to me and my panty has blood. He trips me and I fell down and cried. He covers my face with a cloth and climbs on top of my body. My panty has blood and I always bleed. He did this thing in the bedroom and he locked the door and closed the windows. I could not get out. My mother was at work. He did this dirty thing to me on many occasions. I used to come home from school before my sister and he used to be at home, coming already from work."

On investigation it was discovered that Rachel's father was removing her from the Place of Safety for days at a time, on the pretext that he was buying her school clothes and insisting that it was his right to remove his child whenever he wished.

Rachel's mother denied the abuse, ascribing Rachel's symptoms and all the family problems to witchcraft.

In view of her parents' attitudes and their poor co-operation, Rachel was placed with foster parents in May, 1988.

In the foster home Rachel started to manifest uncharacteristic acting-out behaviour, screaming attacks and *restlessness*. The foster placement eventually broke down when Rachel started to steal and was severely beaten by her foster parents. She was removed from foster care and placed in the children's home in March, 1989.

2.1.2. PRESENTING SYMPTOMS (1ST PSYCHIATRIC CONSULTATION)

The social worker who placed Rachel at the children's home was concerned about her mental state on arrival at the there. She reported the following symptoms:

- **Withdrawal,**
- **Apathy,**
- **Often weepy,**
- **Uncommunicative,**
- **Showed little interest in food or play,**
- **Always had dark rings under her eyes.**

At the first consultation on 17/03/89, a diagnosis of a **Major Depressive Disorder** was made and Rachel was treated with Amitriptyline in a starting dose of 75 mg nocte.

2.1.3. PRESENTING SYMPTOMS (2ND, 3RD CONSULTATIONS)

The response to the above treatment for Rachel's depression was unsatisfactory and at follow-up visits it became obvious that in addition to the depressive symptoms, **Rachel was extremely anxious and she was exhibiting increasingly disturbed behaviour** at the children's home.

The features of this behaviour were as follows:

Features of behaviour (see Appendix 1 and 2)

- *Nervousness*:
  Rachel's anxiety would be particularly prominent after her parents' visits, when the staff often had difficulty pacifying her. On these occasions she would have sleepless nights;

- **Nightmares:**
  Rachel was frequently disturbed at night by bad dreams. She would often awaken screaming in terror and complaining about a snake which was bewitching her, saying that she thought the snake was her father. The dreams were particularly troublesome after her parents' visits;

- **Difficulty in awakening in the mornings and falling asleep during the day for short periods,** after which she would awaken as if startled;

- **Intrusive recollections**:
  Rachel reported frequent recollections of an incident in which her father had tried to choke her in order to silence her during one of the abusive episodes;

- **Over-reactivity:**
  The staff at the children's home and Rachel's teacher reported that she over-reacted to being scolded. She would weep uncontrollably and on occasions ran away from school alleging punishment by the teachers or excessive homework;

- **Screaming attacks at school:**
  Rachel often stopped writing and screamed uncontrollably for no apparent reason;

- ***Hysterical* behaviour:**
  The dentist could not complete his examination;

- ***Moodiness*, restlessness and disinterest in the other children:**
  This was reported at the children's home where she also showed no enthusiasm about play or other activities;

- **Somatic complaints**:
  She frequently complained of headaches.

2.1.4. RACHEL'S MENTAL STATE AT PSYCHIATRIC CONSULTATIONS

Rachel presented initially as a **thin, sad-looking child** with dark rings under her eyes. It was noted that her mother related warmly to her in the waiting room, but Rachel seemed **detached and distant** in these interactions. She smiled politely in response to my efforts to put her at ease and answered questions directed to her by the Xhosa-speaking social worker who interpreted for me. Periodically Rachel **glanced anxiously around the room and at her mother** who cried a lot during the session, expressing her distress that her child had been taken away from her. Rachel's mother could not be drawn into assessing the situation from Rachel's perspective and clearly showed massive denial of any problems in their lives. **Rachel looked on helplessly**.

In a second session Rachel was interviewed alone in the presence of the social worker. She had brought some drawings which I had requested in the previous session and we discussed these, using them to elicit feelings

which Rachel found difficulty in expressing spontaneously. In the drawings **Rachel depicted herself as a very sick child (see Plate V,** between p.79 and p.80) who has been brought to the doctor by ambulance to be healed. She was reluctant to leave the session.

Rachel spoke with some difficulty about the reasons for her *sickness*, which prevented her from *learning well* at school. She said that **she kept thinking about the things her father had done**. She believed that she had been **bewitched**, that her mother no longer loved her and that she had been *thrown away*. The worst events of her life had been the repeated traumatic rape by her father and the episode of theft, when she stole R50 from her foster parents. **She felt *bad*** and in a subsequent session **painted herself as a street-girl without hands (see Plate II and Plate III** overleaf**).** When asked about her hands, she produced a replica of one of her hands by drawing around it and then covering its surface with **numerous wounds** (she said they were cuts - **see Plate IV** overleaf). Interestingly Rachel depicted her entire family with smiling faces and without hands.

In the third session Rachel presented a smiling face but was **agitated about court proceedings** in which she was to have given evidence against her father. Her parents had not arrived in court, nor had her mother visited her at the children's home. She was **extremely distressed** and soon broke down crying bitterly. At this stage she felt **abandoned** by her family.

2.1.5. PERSONAL BACKGROUND AND PREMORBID PERSONALITY

Rachel was born at the Peninsula Maternity Home after an uneventful pregnancy. Her birth and early childhood were normal. It is alleged that Rachel is not her father's child, as she was conceived during a period when her father was in jail. Furthermore Rachel's father is reputed to have been rendered sterile in a motor vehicle accident. According to her mother, Rachel was always a compliant, quiet and healthy child, who was enthusiastic about school attendance and who apparently made good progress at school. She got on well with other children.

In the family Rachel was often called upon to control her father when he became violent. She had a quiet way of handling him, unlike the aggressive manner of her sister.

2.1.6. FAMILY BACKGROUND

Rachel's family background is a multi-problematic one. The family are financially dependent on Rachel's aggressive, epileptic, alcoholic father. He frequently violently assaults his wife and Rachel's older sister, but only Rachel has been subjected to repeated brutal rape by him. Rachel's mother appears to be an uninsightful, submissive woman, who attributes all

PLATE II

RACHEL'S DRAWING

The *street child* without hands

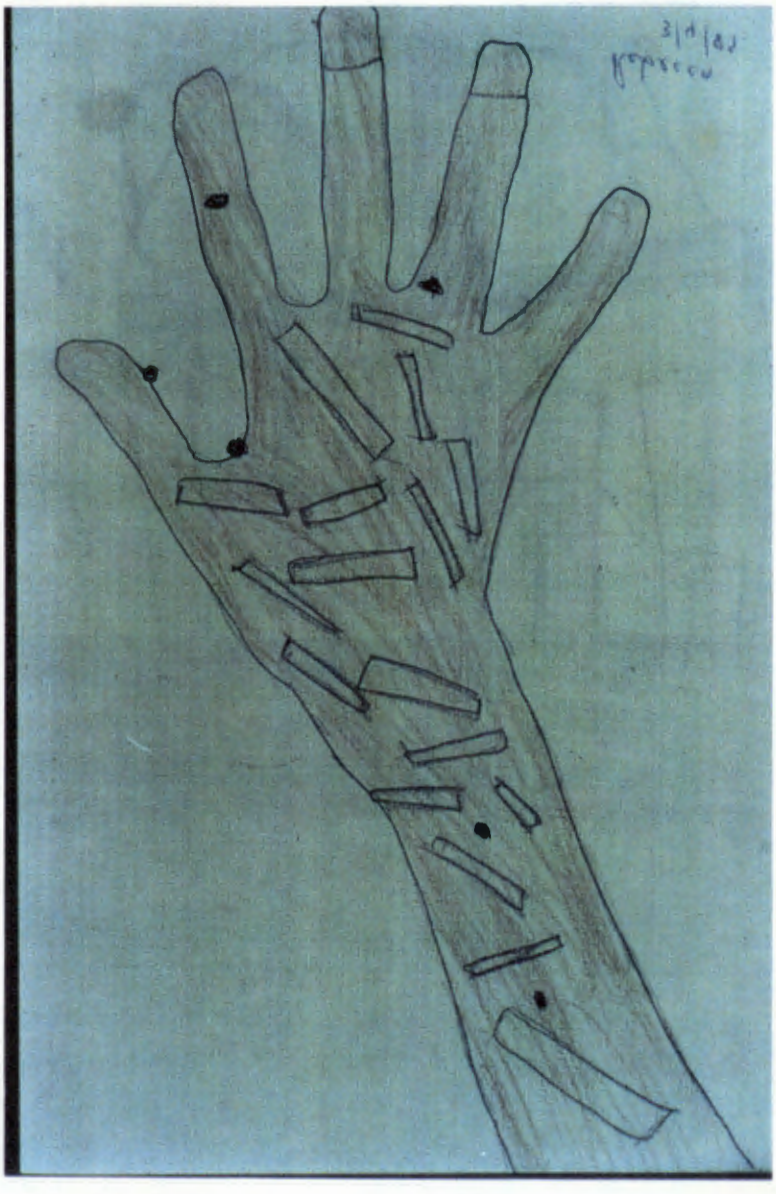
PLATE III

RACHEL'S DRAWING

The *street child* without hands, with companion

PLATE IV

RACHEL'S DRAWING



The *scarred hand* which warded off blows

PLATE V

RACHEL'S DRAWING

The *sick child* arrives in hospital

misfortunes in the family to witchcraft. Despite her warm display of affection towards Rachel, she repeatedly accused her of lying about the abuse.

2.1.7. COURSE AND MANAGEMENT

The diagnosis of Post-Traumatic Stress Disorder was made two months after Rachel's admission to the children's home (see Appendix 1 and 2). At this stage her **level of functioning was poor** (30 on C.G.A.S.) despite adequate doses of tricyclic antidepressant (Appendix 4).

An attempt was made in the assessment period to involve the Xhosa-speaking social worker from the agency concerned in Rachel's treatment and support, as Rachel appeared to relate well to her in the assessment sessions. The principles of treatment were discussed; including. providing an empathic supportive setting in which Rachel could work through her traumatic experiences. However, this treatment was not undertaken, apparently because of work overload.

The staff and particularly Rachel's careworker were briefed by myself about the nature of the disorder and the requirements of the child in terms of support. The importance of being able to share her experiences with an empathic adult was emphasised, as was the need to protect Rachel at this stage from excessive anxiety and feelings of insecurity provoked by her father's visits. It was suggested that a staff member should assure Rachel of her security before the visits and should be nearby to ensure her safety on these occasions.

No further specific treatment was provided and medication was discontinued in view of its failure to have any obvious beneficial effects.

Rachel's mother visited her regularly at the children's home after a few conjoint sessions were undertaken with mother and daughter to facilitate communication which had broken down over the court proceedings. It was noted by the staff that their relationship was at first distant and that Rachel appeared to be angry with her mother.

2.1.8. SIX-MONTH FOLLOW-UP

At the six month follow-up, some of Rachel's post-traumatic symptoms were still evident; namely, occasional nightmares, avoidance of reminders and fears of seeing her father. However, Rachel had gained weight, was making satisfactory progress at school and was participating enthusiastically in the activities of the home. The staff reported that **she was a responsible, likeable child with leadership qualities** which had become increasingly obvious as her symptoms of withdrawal disappeared and her relationships with the other children grew.

The staff also reported an **improved relationship between Rachel and her mother**. Rachel now looked forward to her mother's visits although she **continued to express fears** about going home and spent weekends with relatives. Her level of functioning was assessed as 80 on the C.G.A.S. (Appendix 4).

Rachel continued to make good progress and eventually **became a role model for the other children at the home.** In particular, her ability to express her needs enabled her to elicit the support she required.

2.1.9. TWO-YEAR FOLLOW-UP

At the 2-year follow-up Rachel was spending time with her parents and no longer expressed fears of being with her father. She felt that she had been strengthened by her stay in the children's home and that she was able to avoid abusive attacks at home. At this stage it was reported that Rachel's functioning was superior (Appendix 4) and that she was symptom free.

Rachel has subsequently returned home and attends school in Khayelitsha. At her last follow-up she was progressing well. She is fond of music and sings in the community choir. She is **apparently asymptomatic** and because of her favourable progress, the court order was removed this year and her file closed at the social agency on 15.07.92. When I inquired after her well-being the agency were unable to supply any information about her current whereabouts and the telephone number of a neighbour had been discontinued.

2.2. CASE 2: "EMILY"

"Emily"
Date of birth: 17/03/77
Date of presentation at Child & Family Unit: 13/03/90

2.2.1. PRESENTING HISTORY

Emily had been sexually abused by her father since she was four years old. When she was 12 years old she witnessed her mother assaulting and killing her 15 year old sister, who had also been sexually abused by Emily's father. Her mother believed that the sister had seduced her husband. At her sister's funeral Emily heard her father exhorting the people to kill her mother for what she had done. The people burned down her mother's shebeen in her presence. Emily's mother was jailed and Emily was left in the care of her father who continued to abuse her.

When Emily started to behave strangely, she was taken by the family to a Zionist faith healer, who exorcised her telling the family that she was *demonized*. The exorcism involved immersion in water, the swallowing of a small snake as *muti*, and some terrifying rituals, in which incisions were made into the skin of Emily's abdomen. She reacted to this procedure by manifesting even more disturbed behaviour. Her behaviour was handled punitively by her family. Emily was told that she had been bewitched and was an *evil* agent.

It was only when Emily's brother, aged 16 years was interviewed by the social worker on account of thieving, that Emily's plight came to the attention of the social services. Her brother reported the abuse and Emily was removed from her home on 25/05/89 and placed in the children's home.

2.2.2. PRESENTING SYMPTOMS AT PSYCHIATRIC CONSULTATION

Nine months after admission to the children's home, Emily's case was presented at a meeting. Her ***strange*** behaviour had been noted on her arrival there, but it was tolerated by the staff, as she was considered ***not very bright***.

2.2.3. DESCRIPTION OF BEHAVIOUR

- **Emily failed to adapt to the social milieu** of the home. The staff felt that she was continuing to act strangely after adequate time to adjust to the environment;

- **She related poorly to peers,** becoming involved in violent altercations with them or avoiding them and wandering off on her

own. The other children called her *mad* and ran away from her. She preferred the company of younger children;

- **At times Emily's behaviour was *bizarre*** and this inappropriate behaviour was becoming increasingly disturbing to the staff and disruptive in the home. Emily often undressed and went naked to a pool of stagnant water some distance from the home. She behaved as if in a trance, screaming, beckoning and gesticulating to imaginary people. She appeared to be performing rituals in the water. She could not be pacified on these occasions. She said she was recollecting the time she was taken to the dam to get rid of the *evil*;

- **Emily often had nightmares and awakened screaming**, saying that her father was calling her to come to him and that he appeared with the body of a person and the head of a snake. The staff had difficulty in pacifying Emily when she awakened after dreaming;

- **She was frequently preoccupied** and said she saw the snake and that it spoke to her when she was alone;

- **At school she was unable to concentrate** and the teachers reported that Emily could not learn to read and write. At times she appeared unaware of what she was doing and on these occasions was observed to be writing *upside down*. She had not progressed beyond Sub A after attending school regularly;

- **She behaved in a sexually provocative way with males** and often disappeared in the company of a male.

In view of her strange behaviour and poor functioning at the children's home, the staff were concerned about the possibility of psychosis in Emily.

2.2.4. EMILY'S MENTAL STATE AT PSYCHIATRIC CONSULTATION

Emily presented as a tall, shy, neatly dressed young adolescent. She was polite and impressed as a sensitive girl who was very conscious of her poor background and educational level. She spoke Xhosa and Afrikaans equally well and was able to give a satisfactory but unsophisticated account of herself.

She was anxious, but apsychotic and not obviously depressed at the time of consultation.

Despite her apparent lack of education, Emily was able to supply a detailed description of some of her experiences. Generally, she spoke freely about

them, but stopped now and then, appearing to lose track of what she had been saying. I was not always able to redirect her to the content of the subject under discussion. She would simply look steadfastly and blankly at me as if she had **deliberately *shut off*. Some of my questions to her were simply ignored**, while she fidgeted anxiously with her clothes.

Emily could not describe the witnessing of her sister's death at her mothers hand, but **covered her eyes with her arms and made strange noises.** She also found it difficult to talk about the sexual abuse, but eventually was able to disclose the terrible fear of her father and the fact that he *came to her* every morning while she slept and *found her*. This always resulted in bleeding around the genitalia. *My pa het my gemors* she said.

It was clear that Emily was unwilling to attempt any activity that would expose her as ignorant or incompetent. She refused my invitation to draw at this and other interviews, but eventually emerged as a creative child, once trust was established in the therapeutic milieu.

The interview with Emily confirmed that she was experiencing a number of symptoms of Post-Traumatic Stress Disorder (Appendix 1 and 2).

A feature that emerged at subsequent interviews with Emily was her **profound survivor guilt**. She felt that she was a *bad* person and *stupid*. Yet she was enjoying good food and shelter, while her sister was dead and her mother had gone to prison. She kept asking God to forgive her and would kneel down suddenly, praying fervently.

2.2.5. PERSONAL BACKGROUND AND PREMORBID PERSONALITY

Emily was the seventh child in her family. Prior to her birth, her parents had lost three of their children, who died in early childhood. Emily was born by forceps delivery. At the age of three months she experienced a cyanotic episode which necessitated her admission to hospital. Since then her mother felt protective towards Emily and she developed a warm, affectionate relationship with her. Emily received very little schooling as her parents showed little interest in the education of their children and Emily was always with her mother.

It appears that Emily was always an affectionate, loveable child, who got on well with her sibs, especially with the sister who died.

2.2.6. FAMILY BACKGROUND

Emily's family lived in **appalling socio-economic circumstances**. As a result of these circumstances and her mother's imprisonment, family life disintegrated to the extent that the family members could no longer be traced two years after Emily's admission to the children's home.

The educational level of Emily's parents was extremely low (both illiterate) and their conflictual relationship was an unstable one. Emily's father divorced her mother when she went to prison and got custody of the children. However, at this point, **Emily's brothers took to the streets for survival.** Two of them married, one was placed in a children's home and the other was caught stealing and placed in a school of industry.

Emily's father was not a good provider for his family. He worked as a labourer, but spent his money largely on alcohol and *other women*. His wife had tried to increase the family income by selling wine, but was not very successful.

The father's long-standing abuse of his daughters was apparently known to the family, but tolerated, as the children were rewarded by their father for their sexual favours to him and this money was used by Emily's mother for the upkeep of the family. It is not clear whether Emily's mother killed her daughter over a *money* feud or because she had become jealous of her.

The family had always been **religious,** belonging to the Church of Zion and attending services regularly.

When Emily's mother returned home from prison, she made promises to provide for her children, but could not do so and became a vagrant. Emily's father disappeared.

2.2.7. COURSE AND MANAGEMENT

On account of her **severe symptoms and poor functioning** at the children's home, Emily was admitted to the psychiatric in-patient ward at the Child and Family Unit shortly after psychiatric consultation on 13/03/90.

During the first month of her stay in the ward, Emily was **noticeably anxious and expressed fears** that her father would come and take her away. She was often afraid to go to sleep at night and **would not sleep alone.** Sometimes she was unable to fall asleep because of her fearful thoughts. At first she had **frequent nightmares and awakened crying**. She was also troubled during the day by intrusive recollections, the themes of which were similar to the nightmares.

2.2.8. REPETITIVE THEMES REPORTED:

She reported the following:

- **Being strangled by a snake** with the head of her father and the body of a human. The snake approached her at moments when she was alone and called her, persuading her to *trou met* (marry) him. Sometimes the snake-heads were interchangeable and other people would appear in this form. Father and sister might appear together and bind her hands;

- **Being killed with a knife and decapitated**. Emily would see her head lying on the ground;

- Dreams of people hitting her and headless black people with no bodies (or appearing as snakes);

- **Repetitive recollections of her sister's funeral**, her father's shouting and her mother's screaming;

- **Dreams of her father chasing her with a knife** and threatening her. She could never run fast enough and would be caught by her father, awakening in a panic, as he twisted her wrists.

At times she seemed confused between reality and her dreams/recollections, claiming that the careworkers and her mother or aunt were having violent altercations, or saying that she would write to thank her mother for the lovely cake that she had made for her (after eating cake supplied by a staff member). She also **complained of abdominal pain** attributing this to the snake, which she believed was still inside her.

Emily's anxiety was made worse when other children in the unit fought with each other. She would then complain of headaches and say that she felt *deurmekaar*. She said that she was afraid of living in the children's home, as the boys would *mess her up*. Yet she was often **sexually provocative** towards males and apparently unaware of her behaviour. When one of the younger male children made a mock attack on her and forced her to the ground, she **became terrified and helpless**. At a later date, she recalled the incident and vowed to kill the child if he repeated the act. The same child induced extremely **regressed behaviour** in Emily, when he called her a *hotnot* and a *kaffir*. She became infantile and insisted on wearing a baby's bonnet for some time.

Generally, Emily was kind to other children. She only became aggressive when others provoked her. **Her self esteem was extremely low.** She said that her pictures were *too ugly* or that she would end up alone as she was ugly. She was afraid that if she stayed in the children's home for five years no-one in her family would remember her.

2.2.9. AFTER ONE MONTH IN THE THERAPEUTIC MILIEU

After a month in the therapeutic milieu of the ward, **Emily's overt anxiety was no longer obvious and although she continued to report dreams about snakes etc., she said that they did not frighten her anymore**. At this stage she started to speak about the longing for her family members, expressing constant concern about their welfare (whether they had enough food, clothing, etc. She experienced **profound survivor guilt** and this proved to be the focus of her preoccupation for the subsequent 4 months of her stay in the ward.

Emily's mental and emotional state continued to improve throughout her stay in the ward, but she experienced a temporary exacerbation of anxiety and nightmares, when she returned to the ward after the three-week July vacation. It seemed that Emily, although improved in her functioning, still required the close contact of supportive professionals for a sense of security and well-being. She said she felt *safer* in the ward.

2.2.10. SIX MONTH FOLLOW-UP (APPENDIX 4)

Six months after her presentation to me, Emily was discharged from our unit. At this stage she **functioned well** (80 on C.G.A.S.), although she was still not able to read and write. However, she had learned to express her needs and requested that she be taught to sew, as she felt this might enable her to earn a living one day. **She felt that she was *strong* enough to face her father** and actually did so, when he visited her at the children's home, expressing her disappointment in him and his care of the children. She wanted to return home to help the family. Symptoms of P.T.S.D. were minimal. She continued to report dreams, but they could be discussed without fear and some of her dreams were pleasant ones. **She behaved and dressed more like an adolescent and less like a child**, taking care with her physical appearance and grooming.

2.2.11. TREATMENT IN THE WARD (APPENDIX 6)

With regard to her treatment in the ward, **Emily was able to make excellent use of the supportive setting** and professional assistance to work through her traumatic experiences and to develop her social skills. **Music therapy proved particularly successful** in Emily's case, as this enabled her to express herself without restraint in a familiar medium, which involved rhythm and melody (not scholastic skills). Emily clearly enjoyed the sessions. However, she said that she disliked the flute because it gave her bad dreams.

2.2.12. EXAMPLE OF EMILY'S WORK

An example of her work is illustrated in these songs which Emily composed and put to rhythm with the help of her therapist:

There were two sisters
Their names were Ngini and Ngunu.
Ngini 'messed' in the house and blamed Ngunu.
The mother killed Ngunu.
The mother made Ngini work hard.
Ngunu came from the dead to help her with the work.
Ngini became very angry with her mother.
She drowned her in the river.
Then the father confronted Ngini.
She drowned him too.

I want to be with my mother,
But I can't get to her.
I want to be with my father,
but I am afraid of him.
He has hurt Emily.

I feel sad. My sister cannot hear me.
I feel mixed up.
I am longing for my brothers
I feel sad.

But,
God will help me.
If you believe,
And I believe,
Then Africa will be saved.
The Holy Spirit must come down
And Emily must be saved.

Emily often became *hypnotised* in the process of singing. She would chant and behave as if in a trance, singing:

"Jesus loves me
God is all powerful
God can work miracles"

The **progression** from the experience of trauma and its associated feelings to an experience of being comforted is clearly demonstrated above. Emily appeared to have found her own solution in religious conviction and her belief in salvation, with the assistance of her therapist.

2.2.13. EMILY'S SUBSEQUENT COURSE

Emily's subsequent course has been a remarkable one. She was transferred in March 1991 to another children's home in the Ciskei. A social worker

who had befriended her and maintained contact with her throughout her stay in the children's home, was working there. As this was the only adult who showed an ongoing interest in Emily's welfare and invited her to stay during holidays, it was considered that the move would be a beneficial one. She has subsequently learned to read and write, and her general development as an autonomous adolescent has proceeded without mishap.

2.2.14. TWO-YEAR FOLLOW-UP (APPENDIX 4)

At two-year follow-up when she visited the Child and Family Unit while on holiday in Cape Town, she was well and asymptomatic but still expressing the desire to be reunited with her family.

2.2.15 THREE-YEAR FOLLOW-UP (APPENDIX 4)

At the three-year follow up Emily impressed as a reasonably well adjusted adolescent. She was being fostered by the social worker who had taken an interest in her, had learned needlework skills and had developed a more positive view of her future. However, she still demonstrated marked **survivor guilt** and the social worker reported a tendency to act out occasionally. She was not willing to speak about the traumatic events of the past but hoped that she would be reunited with her family.

2.3. CASE 3: "CYNTHIA"

"Cynthia"
Date of birth: 5/03/76
Date of presentation at Child and Family Unit: 23/04/90

2.3.1. PRESENTING HISTORY

Cynthia was admitted to the children's home on 27/09/89 following a series of ordeals which she had experienced after her arrival in Cape-Town from the Transkei at the age of twelve years.

Her move to Cape Town was arranged by the family because Cynthia's elderly grandmother, with whom she and her brother lived in the Transkei, had become ill and finances were dwindling.

On arrival in Cape Town, Cynthia and her brother were initially accommodated in a *hokkie*, where her sickly, alcoholic mother lived with a male companion.

Shortly after their arrival, Cynthia's mother died and Cynthia and her brother moved into the home of a maternal aunt and her husband.

Cynthia's uncle made several unsuccessful sexual approaches to her during her stay with the family. Eventually she was violently raped by him as she lay sleeping on a mattress which served as her bed in the kitchen. Her uncle threatened to kill her if she protested. Cynthia's aunt was at work at the time. However, the neighbours were alerted by Cynthia's screams and rescued her. The details of her experience have never been divulged by Cynthia, but she required admission to hospital for her injuries and her uncle was arrested and sent to Polsmoor prison.

The aunt, a heavy drinker, was extremely annoyed about the incident and allegedly assaulted Cynthia prior to her hospitalisation. She blamed Cynthia for the rape and rejected her. The aunt claimed that Cynthia was *bad* and that there were rumours that she was a seductress, as her mother had been. Cynthia's younger brother, on the other hand, was well liked and accepted by his aunt.

Cynthia was removed from this home by the social services and placed in another foster home where she was unhappy and claimed that she was being maltreated. After an investigation, it was considered that it would be in Cynthia's best interests to place her in a children's home.

2.3.2. PRESENTING SYMPTOMS AT PSYCHIATRIC CONSULTATION

When Cynthia was admitted to the children's home, she initially made a good impression as an intelligent, mature adolescent. However seven months later, her case was discussed at a consultation meeting and the following symptoms presented:

- ***Visions*:**
  Cynthia often claimed that she saw a man at the window threatening to kill her. When it was pointed out that this was not so, she said she was recalling past experiences;

- **Inappropriate laughing:**
  She said that she was hearing the voices of people she had known in the past calling her to come to them;

- **Anxiety at night:**
  She was always reluctant to go to bed and always covered her head with a blanket because she felt this would protect her in some way;

- **Bad dreams:**
  She was unable to relate the content of her dreams but would become preoccupied after dreaming;

- ***Telling stories*:**
  Cynthia showed no emotion recalling the traumatic events in her life. She related past events in a *matter of a fact* way. For this reason, people thought that she was making up stories about her experiences, yet the staff were aware that these events had occurred;

- ***Moodiness*, withdrawal and lack of spontaneity:**
  She often seemed to be *in another world;*

- **Irritability:**
  Her relationship with her peers was affected by her tendency to become extremely irritable, sulky and rejecting;

- **Poor concentration:**
  Despite her apparent intelligence, it was reported that Cynthia had difficulty in concentrating and grasping concepts at school. For these reasons she said that she disliked school.

The staff did not find that Cynthia's behaviour was disruptive in any way, but they felt that she was *moody* and difficult to understand. They were also concerned about the *visions* and *voices* which she was experiencing.

2.3.3. CYNTHIA'S MENTAL STATE ON PSYCHIATRIC CONSULTATION

Cynthia's appearance was that of a sturdily built and physically healthy looking child, who entered the consulting room with an **air of bravado**. She was co-operative and eager to please, but had to be interviewed with the assistance of an interpreter, as she spoke only Xhosa. Her mental state was unremarkable, but she spoke about her personal background in a **detached manner and related her traumatic experiences as if reciting a script.** She confirmed the presence of symptoms which had been presented by the staff in the same detached manner, showing no anxiety when speaking about the ***visions*** **and** ***voices***. She did not disclose details of the trauma and in particular, **could not reveal the content of her bad dreams**, saying she had forgotten. She seemed more resentful towards her aunt than she did towards her uncle, saying that her aunt drank too much, was *jealous* and she feared for her brother's safety in their house. She expressed these views in an unemotional, almost arrogant manner, swinging her legs as she did so. However, she **frequently cracked her knuckles** loudly in a ritualistic manner between questions. This was the only overt manifestation of anxiety.

2.3.4. PERSONAL BACKGROUND AND PREMORBID PERSONALITY

Most of the information about Cynthia's personal background has been provided by Cynthia herself and confirmed by the superintendent of the children's home. Details about her birth and early childhood could not be supplied.

Cynthia was born in Langa, Cape Town, but was **sent to the Transkei at an early age to be cared for by her maternal grandmother.** She recalls an uneventful, peaceful childhood in her grandmother's home, where she assisted her grandmother with chores and played amongst the sheep and goats with the neighbour's children.

She experienced early failure when she attended school as a late beginner, because she could not understand English or Afrikaans. However, she overcame her difficulties and did well at school.

Cynthia reports that she was always close to her grandmother, but the latter complained about her ***quietness***. Cynthia feels that she has always had **difficulty in social interactions** as she is *shy*.

2.3.5. FAMILY BACKGROUND

Cynthia's parents were not married. Her father died when she was very young. Her **mother struggled** to earn a living in Cape Town, **drifted into poverty** and became *sickly*. She ultimately **died in abject circumstances.**

It appears that Cynthia's mother was dominated by her **older sister, who, with her husband, subsequently became Cynthia's guardian.** This aunt had always played a large role in determining Cynthia's welfare, as she dictated the course of action in the family. For this reason Cynthia believes that she has been **betrayed by her aunt** and is bitterly resentful towards her for favouring her younger brother and rejecting Cynthia.

Cynthia's grandmother continues to live in Ncobo, Transkei, but she is old and frail and not able to provide a home for Cynthia.

2.3.6. COURSE AND MANAGEMENT

At presentation it was considered that Cynthia's **post-traumatic stress symptoms were moderately severe (Appendix 1)** and that although her behaviour was not disruptive in the home, her functioning was poor. She appeared to be preoccupied with events of the past to the extent that she could not accomplish expected developmental tasks despite her good intelligence.

2.3.7. ADMISSION TO THE PSYCHIATRIC WARD FOR CHILDREN

It was decided to admit Cynthia to the psychiatric in-patient unit for treatment as Emily was in the unit at the time, and the possibility was entertained that a mutually supportive relationship might be developed between them with the help of professionals.

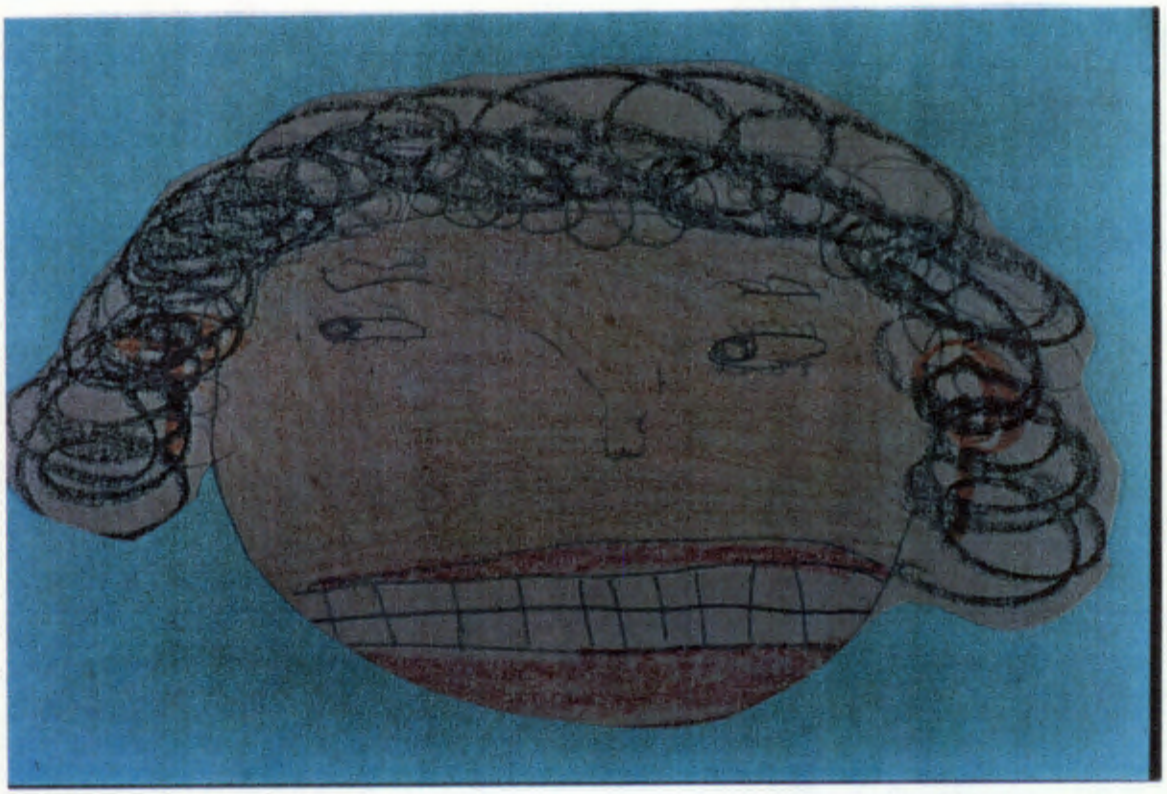
Cynthia formed an immediate, but apparently superficial attachment to the ward, saying that she preferred it to the children's home because she felt safe.

Within a week her anxiety about going to bed at night settled, and she slept peacefully. She also reported that she *enjoyed* the ward, because she was no longer experiencing the *bad things* that had happened to her.
However, it was noted that **Cynthia was often preoccupied** and, when questioned, admitted to **thinking about the rape** ordeal. She evaded any discussion about this, or if she spoke about the incident would do so in the same **detached** manner in which she had presented it. She could not be drawn into a discussion about her feelings about the rape, although she presented a drawing of herself as an angry, fearful child (**see Plate I** in front **and Plate VII** overleaf).

When asked about **feelings of fear and anger, she admitted to these but always directed them towards her aunt,** saying she was angry with her and feared for her brother's safety because her aunt was always so irritable after drinking.

PLATE VII

CYNTHIA'S DRAWING



Cynthia's portrait of the angry, fearful child

Cynthia tended to be **aloof with other children and she lacked spontaneity**. It was difficult to engage her in therapeutic activities. She wanted to participate in these activities only on her own terms and would even change a game to suit her particular needs. **She often became irritable, sulky and intolerant** in the company of the other children. Sometimes she would lash out angrily at a much younger child who was irritating her, or she would simply withdraw.

She frequently used somatic complaints as a means of attracting attention.

Her scholastic performance fluctuated while she was in the ward. The teacher reported good intellectual ability, but Cynthia indicated her motivation was conditional and that she was not interested in going back to her old school.

After the initial improvement in symptoms of anxiety and *re-experiencing* phenomena (visions, voices, etc.), **no further progress** was noted in the ward. Cynthia continued to avoid feelings and expressed them only indirectly.

Efforts to foster a mutually supportive relationship between Emily and Cynthia were largely a failure. The relationship seemed a competitive one in which Cynthia expressed her contempt for Emily's lack of scholastic skills and Emily retaliated angrily.

Attempts to involve her paternal family and to find suitable foster parents for Cynthia were unsuccessful and resulted in another experience of rejection for her.

2.3.8. TREATMENT IN THE WARD (APPENDIX 6)

Treatment in the therapeutic milieu had been difficult for a number of reasons, but primarily because of **communication difficulties.** Apart from Emily there were no Xhosa-speaking children in the unit and none of the careworkers were able to speak Xhosa.

For the above reason, the **assistance of a Xhosa-speaking therapist** from another unit was sought for Cynthia.

Cynthia was discharged after spending three months in the ward. She appeared to experience her **discharge as another rejection,** despite the fact that she was to receive ongoing therapy with her Xhosa-speaking therapist.

2.3.9. SIX-MONTH FOLLOW-UP

It was reported that she **made good progress during the therapy sessions** and at follow-up six months after her psychiatric presentation, was showing improved functioning socially and at school. At this stage her score was 70 on C.G.A.S.

Subsequently, after discontinuation of her individual therapy (because of therapist's work pressures), some of her **symptoms recurred** and although her sleep problems and intrusive recollections disappeared, she functioned poorly at the home and at school (Appendix 4).

2.3.10. TWO-YEAR FOLLOW-UP

At the 2-year follow-up, Cynthia is experiencing ongoing rejection by her aunt, who threatens her and verbally abuses her when Cynthia visits her brother. Holidays are spent with her elderly grandmother in the Transkei.

Cynthia remains angry with her family, in particular her aunt, as they have apparently disowned her, making no effort to maintain contact.

She is still unable to express her post-traumatic feelings appropriately, continues to worry about her brother, has failed this year at school and is generally a **poorly-adjusted member of the children's home (Appendix 4).** She functions at 40 on the C.G.A.S.

2.4. CASE 4: "NOMSA"

"Nomsa" aged 9 years at presentation
Date of birth: 13/07/79
Date of presentation at Child & Family Unit: 11/06/90

2.4.1. PRESENTING HISTORY

Nomsa was well-known to the Red Cross Children's Hospital as she had presented there on many occasions with **pseudoseizures**. A psychiatric diagnosis of **Conversion Disorder** was made but despite her attendance at a psychiatric clinic, hospital visits for disturbed behaviour became increasingly frequent in 1990.

Brief periods of hospitalisation resulted. During these admissions, it was noted that Nomsa was in a state of hyperarousal: she slept restlessly and awakened in an anxiety state after nightmares. On one of these occasions Nomsa **revealed the apparent cause for her anxiety**, when she awakened one night screaming continuously: ***"I did not tell the people about "Z". He will kill me with a gun."***

Eventually, Nomsa presented in a **pseudopsychotic state** and was admitted to the emergency ward of Red Cross Children's Hospital. Her **screaming, lashing about and bizarre seizures** caused such disruption in the ward that an urgent referral was made to the psychiatric department and I was consulted. Nomsa required heavy sedation and was transferred to the psychiatric services.

2.4.2. PRESENTING SYMPTOMS AT PSYCHIATRIC CONSULTATION

At the psychiatric consultation the following information was provided by Nomsa's mother about her behaviour and symptoms:

- **School absences**:
  From March 1990 Nomsa's teacher reported frequent absence from school. Nomsa could not give an explanation for this;

- **Running away from home:**
  Nomsa ran away from home to her grandmother's house for no apparent reason. She was given a hiding by her mother for the above behaviour;

- **Loss of appetite:**
  For about the same period she showed little interest in food and lost weight;

- **Personal neglect:**
  Her mother complained that Nomsa was becoming increasingly slovenly in her habits and no longer seemed concerned with personal hygiene;

- **Sleepless nights:**
  She was afraid to go to sleep at night and often awakened screaming. Her mother found it impossible to pacify her after these night terrors;

- ***Bizarre* behaviour at home:**
  She would suddenly become violent as if terrified, and start breaking things around her;

- **Poor concentration at school:**
  The teacher complained that Nomsa was not able to concentrate in class and was having *strange fits.* Her scholastic progress was poor;

- **Avoided talking about whatever was frightening her:**
  Nomsa's mother had repeatedly asked her about the reasons for her behaviour but she was evasive.

Eventually in response to her mother's insistent questioning, Nomsa disclosed that she was being sexually abused by a *gang member* who had threatened to kill her if she revealed his identity. Nomsa's mother reported that she had tried to approach the alleged perpetrator, but was warned off by people in the area who said he was dangerous. She said that an appeal to the police had failed to elicit any action.

Despite the above disclosure, Nomsa's mother failed to see the relevance of these stressful experiences with regard to her daughter's behaviour. **She believed that her daughter, an epileptic, had gone *mad.*** She seemed exasperated, but at the same time amused by her daughter's bizarre outbursts. She laughed helplessly, shaking her head disapprovingly while her daughter screamed and lashed out.

As Nomsa's mother was not able to offer any solutions to her problems and **could not protect her in the very difficult circumstances in which the family were living,** arrangements were made for Nomsa's statutory removal from home to a place of safety. Her mother appeared greatly relieved by the decision to accommodate Nomsa temporarily in a children's home, as she herself was struggling to survive and regarded our intervention as assistance.

2.4.3. NOMSA'S MENTAL STATE ON PSYCHIATRIC CONSULTATION

As an interim measure, Nomsa was admitted to the psychiatric in-patient ward at the Child and Family Unit, where she could be prepared for her admission to the children's home and interviewed in a supportive setting.

After the acute episode of pseudopsychotic behaviour had settled, Nomsa presented as a pleasant child who made good contact with me even although we had to relate through an interpreter.

She was anxious, spoke rapidly, and sucked her thumb throughout the interview. She expressed concern about her safety in the ward and asked if it would be safe at the children's home.

There were **bilateral linear scars** on her face, indicating a probable visit to a traditional healer. Nomsa could not supply any information about the scars and when Nomsa's mother was questioned about them, she said that Nomsa had run into a fence.

Nomsa's account of the sexual abuse was a rather garbled one. She spoke nervously about "Z", looking around the room as if she expected him to appear. She said he had *forced* her and held a knife at her throat while she had to do *dirty things*. She could not give detailed explanations of her experiences, being apparently baffled by the questions, and often looking blankly at the interpreter. **She declined my invitation to draw or use toys to demonstrate her experiences.**

She indicated that "Z" was becoming more and more demanding and had repeatedly threatened to kill her. She reported that **she could not sleep at night because of the bad dreams. She believed that she would be killed in a violent manner** and that she had been afraid to go to school in case "Z" found her there.

The overwhelming impression of Nomsa's mental state was one of **insecurity and terror.** There were no overt signs of depression or psychosis at the interview. It appeared that her cognitive abilities were being impaired by anxiety, although this was difficult to ascertain through an interpreter. A diagnosis of Post-Traumatic Stress Disorder was made (Appendix 1).

2.4.4. PERSONAL BACKGROUND AND PREMORBID PERSONALITY

Nomsa's birth and early infancy were apparently normal. At the age of 2 months, she was cared for briefly by relatives in the Transkei but was soon brought back to Cape Town when her mother found her **dehydrated, malnourished and ill at the age of 4 months.**

Her mother reports delayed speech development in Nomsa, but her subsequent development was normal. She attended school in 1986 and initially progressed well.

At three years she developed **fits** and although her E.E.G. was normal, she was given medication (Tegretol). Fits were ascribed to probable old cysticercosis or tuberculosis, as a **calcified granulomatous lesion** had been found in her occipital lobe on skull X-ray.

However, Nomsa was not given regular medication by her **alcoholic grandmother** who was her caregiver at the time. Because of poor compliance and repeated seizures, Nomsa was **admitted in 1988 to St Joseph's home for a 4-month period.**

During the period 1986-1988, Nomsa had not attended school despite the fact that she kept asking to go to school. Nomsa's mother said that there had been **too many problems** during this period, particularly with her **brother** (Nomsa's uncle) who lived in the same house with them. He attended a special school and had **psychiatric problems** which required him to be admitted to Valkenberg hospital.

In 1989 Nomsa re-attended school and soon advanced her position in class from 22nd to 4th.

With regard to Nomsa's premorbid personality, her mother described her as a **pleasant, *normal* child when well. She had always expressed the desire to learn and to do well.**

2.4.5. FAMILY BACKGROUND

The family's socio-economic background was an extremely poor one. Nomsa's parents were not married and her father had apparently disappeared in 1988 shortly after the birth of a second child. Nomsa's mother moved from ***hokkie* to *hokkie* because of violence and alcohol abuse in the neighbourhood.** She supported her two children, a problematic brother and a pregnant cousin, by charring.

The family have been seen by numerous health workers and assisted with food parcels, clothing etc.

2.4.6. COURSE AND MANAGEMENT

Nomsa's stay in the psychiatric ward was a brief one as her admission to the children's home needed to be arranged urgently. During the week of her stay in the ward she manifested symptoms of anxiety; she was restless, over-talkative, cried a lot, sucked her thumb and complained of headache and stomach-ache.

At night it was noted that she had difficulty falling asleep and sucked her thumb vigorously. However, once asleep she slept well and did not waken with nightmares.

Emily and Cynthia who were already in the ward behaved protectively towards her and she soon bonded with Cynthia.

Nomsa participated readily in the activities of the milieu, but she easily became irritable during rough play with the males - alternatively, she behaved provocatively with them. At times she sobbed saying that she was missing her mother.

2.4.7. TREATMENT IN THE WARD

No specific treatment could be offered because of communication difficulties: there were no Xhosa-speaking professionals in the ward.

Nomsa required sedation while in the emergency ward but thereafter medication was not required. The Carbamazepine was withdrawn as Nomsa's seizures did not appear to be organic in nature. She did, however, receive Bactrim for a vaginal discharge, although an examination could not establish conclusive evidence of intercourse having occurred.

Nomsa was encouraged to speak about her experiences with the other Xhosa-speaking children. She could not do so, but she did say that she did not wish to return home until "Z" had been put into jail.

Nomsa was discharged from the ward and admitted to the children's home on 21/06/90.

2.4.8. FOLLOW-UP AT THE CHILDREN'S HOME

Nomsa bonded well with her careworker who reported that she was a pleasant, compliant and well-motivated child, who related well to her peers.

Her mother maintained contact and visited Nomsa regularly. Nomsa looked forward to her visits.

2.4.9. SIX-MONTH FOLLOW-UP

Nomsa had made an excellent adjustment at the children's home, was asymptomatic and progressing well at school (Appendix 4). Her mother visited regularly. She functioned at 90 on C.G.A.S.

2.4.10. TWO-YEAR FOLLOW-UP.

She has continued to make excellent progress at the children's home, although it is reported that she is a shy, rather *untidy* child who lacks

confidence at times. There has been no need for Nomsa to be treated again at the Red Cross Hospital since she has remained entirely symptom-free. The staff at the children's home appear to have forgotten the reason for her admission. They are more concerned about her mother's socio-economic circumstances. Therefore, they have not considered sending her home despite the fact that Nomsa has a good relationship with her mother who visits her regularly. She has progressed well at school and has passed Std. 3. She has a lively interest in music and sings in the choir. She is presently functioning at 90 on the C.G.A.S. (Appendix 4).

2.5. CASE 5: "BEAUTY"

"Beauty" aged 15 years at presentation
Date of birth: 10/10/75
Date of presentation at Child & Family Unit: 15/03/91

2.5.1. PRESENTING HISTORY

Beauty was admitted to the children's home in April 1989, when she was found roaming around the streets with other children.

Beauty had always lived in an **extremely unstable and chaotic home environment.** At the age of 12 years, however, she suffered a **major adversity** and has continued to be confronted by many traumatic experiences.

When Beauty was 12 years old, her mother went to the Transkei for a long period and **left Beauty and her sibs with a male friend** who abused alcohol. On her return from the Transkei, **Beauty's mother had a fight with this man and stabbed him to death** in the presence of Beauty and her younger sibs.

After her **mother's imprisonment**, Beauty and her sibs lived with various relatives who took little interest in the children and neglected them. During this period Beauty was *gang-raped* by three men who dragged her into the bushes while she was on her way to a shop.

She reported the rape to her grandparents, but when they failed to respond, Beauty decided to leave their home. She **became a street child,** collecting food from bins, sniffing glue, drinking alcohol and stealing to feed herself and her sibs who had joined her.

Beauty was imprisoned and subsequently two unsuccessful placements were arranged by a social agency. Beauty ran away from her caregivers and attempted to return to her mother who had been released from prison during this period. However, she was so seriously **assaulted by her mother** on her return, that she required hospitalisation. She left the hospital and returned to the streets. It was at this juncture that she was placed in the children's home.

2.5.2. BEHAVIOUR IN THE CHILDREN'S HOME

In the children's home Beauty was regarded as a **severely conduct-disordered** adolescent on account of the following behaviour:

- **Sexual promiscuity**:
  She slept away from the children's home at night or brought males back to sleep with her;

- **Aggression** towards other children;

- **Rudeness** to adults;

- **Stealing;**

- **Smoking.**

Beauty also manifested other symptoms which were considered abnormal by the staff. These were **tolerated** being accepted as **part of Beauty's irritable, aggressive and moody nature.**

She was described by the staff as a **bully** with wide mood fluctuations. She was always in conflict with the careworkers and the other children, yet it was observed that she had **good leadership** qualities and abilities in a number of areas.

Beauty was not close to anyone in the children's home. She said it was **difficult to trust people** around her.

It was reported that she was well motivated to succeed at school, but that she had difficulty concentrating. Her progress in Std. 5 was average.

2.5.3. PRESENTING SYMPTOMS AT PSYCHIATRIC CONSULTATION

In March 1991 Beauty was referred to me at the Child and Family Unit by a doctor from the Gynaecology Department at Groote Schuur Hospital after treatment for **venereal disease**. Beauty's behaviour had caused some concern when on attempted vaginal examination by the doctor, she became **psychotic.**

At this stage interviews with the staff of the children's home revealed that Beauty had the following symptoms in addition to the **disturbed conduct** which has been mentioned:

- **Trance-like states, forgetfulness and moodiness;**

- **Sleep problems:**
  She was afraid to sleep alone always asking to be allowed to sleep with other children or staff members. She also complained of sleeplessness;

- **She frequently awakened at night:**
  She said that someone was leaning over her and wanting to harm her - this occurred about twice weekly;

- **The teacher had reported poor concentration in class**:
  Beauty always seemed preoccupied with her own thoughts and would not discuss them.

2.5.4. BEAUTY'S MENTAL STATE AT PSYCHIATRIC CONSULTATION

Beauty presented as a physically well looking adolescent with a serious facial expression. She related appropriately and spoke some English. Although very much in contact with reality, she became **distracted and preoccupied during the interview, as if my questions were sending her into a trance-like state.** When asked, she said she was recalling her past experiences, in particular the **murder of her mother's boyfriend** and the **gang-rape**. However, she would not elaborate on these statements.

She expressed satisfaction with her present environment, saying she was **not unhappy** at the children's home, but she disliked the restrictions placed upon her. She complained of **poor appetite** and **difficulties in concentrating** at school. She said she had problems concentrating because she was **recalling the events of her life** and that this was frustrating because she wanted to do well so that she could become a social worker.

2.5.5. PERSONAL BACKGROUND AND PREMORBID PERSONALITY

Beauty's background had been one of **extreme disadvantage**. There was no information about her birth and early life, except that her birth was apparently unplanned and unwanted as she was the fourth child of an unmarried and antisocial mother. She spent most of her childhood, living with various relatives when she was not with one of her parents. Beauty's relationship with her mother was poor - her mother often physically abused her.

Her **school attendance** commenced at the age of nine years and was **irregular.** This was due to the **frequent moves** between her parents' and relatives' homes. As a result, she failed Std. 2 twice.

As no family members have ever taken any interest in Beauty, there is no information about her premorbid personality. It would appear that **she has tried to parent her sibs as best she could,** but that she has an ambivalent relationship with them in the children's home.

2.5.6. FAMILY BACKGROUND

Beauty's parents were never married. They had a **conflictual relationship** and there were **frequent violent confrontations** over Beauty, maintenance

etc. Her father has a **criminal record**, having spent two years in prison. He is a salesman in Port-Elizabeth but has never contributed to Beauty's maintenance.

Her **mother is an unstable, violent woman** who abuses drugs and alcohol and runs a shebeen. She has been hospitalised for pulmonary tuberculosis.

Beauty's mother has had 9 children by different fathers. Four of these children are presently residing at the children's home.

The maternal grandparents have cared for the children from time to time, but showed little interest in them and have subsequently rejected Beauty's mother. They have not been supportive towards Beauty.

2.5.7. COURSE AND MANAGEMENT

Although the criteria for Post-Traumatic Stress disorder were easily met by Beauty's presentation (Appendix 1), it was **difficult to determine her level of functioning (Appendix 4)**. It has appeared to fluctuate a great deal and was largely affected by disturbances of conduct. However, it was decided that Beauty should receive the benefit of **psychotherapy** to enable her to deal with her stressful experiences in the presence of a supportive adult.

Beauty subsequently received therapy from a **Xhosa-speaking psychiatrist** at the Child and Family Unit.

2.5.8. THERAPY

The therapy resulted in **immediate improvement** in Beauty's moods and a reduced tendency to be preoccupied. There was also improvement in her sleeping pattern and a reduction in acting-out behaviour.

The therapy allowed her to express her **profound anger** towards family members for rejecting her. She also expressed her frustration at having limits set for her. She saw the **future as bleak** and said she would not have children. She believed that she would probably be ill-treated in any house that was not her own.

During the fourth month of her therapy there was a lot of **violence and unrest** in the community in which the children's home is situated. Beauty was **noticeably anxious** during this period and said she feared for her safety. Despite her anxiety she was successful in her school exams, which were written during this period.

2.5.9. SIX-MONTH FOLLOW-UP

Beauty reported that she had no fears or sleep disturbance and that she experienced a feeling of well-being. Her relationships at the children's home seemed better. She expressed a willingness to visit her home for the school holidays. She said she had found it helpful to have someone to talk to and that since she had commenced her therapy, she had been able to control her aggression at the children's home.

The staff confirmed the improvement which had occurred with regard to Beauty's behaviour and mental state (Appendix 4).

2.5.10. TWO-YEAR FOLLOW-UP

Beauty's therapy terminated at the end of 1991 after 9 months attendance at the Child and Family Unit. Since the cessation of her therapy there has been a steady deterioration in her behaviour, with a recurrence of post-traumatic symptoms. She has failed Std. 6 this year (1992), as she did not write her exams. She has been coming and going from the children's home, staying with gangsters in the community and quarrelling with her sibs and the staff. She spent the Christmas holidays with her family in East-London but it wasas reported that she presented at the social agency there in an anxiety state, crying to be sent back to the children's home in Cape Town. She presently functions at 30 on the C.G.A.S. (Appendix 4).

2.6. CASE 6: "YOLANDA"

"Yolanda" aged 10 years
Date of birth: 13/11/82
Date of presentation to Child & Family Unit: 30/08/91

2.6.1. FOREWORD

When the title for this dissertation was submitted, Yolanda's case had not been included in this study, which had originally involved 5 case histories.

Yolanda is the half-sister of Beauty (Case 5).

The documentation of Yolanda's traumatic experiences has been inadequate. Information about them has largely been supplied by Beauty. Some of this data has not been substantiated by other reports and must therefore remain suspect in view of Beauty's own psychopathology and credibility.

However, it was decided that Yolanda's case history should be included in the study because it illustrated some important aspects of the presentation of post-traumatic stress where long-standing physical abuse, deprivation, neglect and the witnessing of violence have been prominent factors in the background history, whereas the sexual abuse appears to have been mentioned as an afterthought.

2.6.2. PRESENTING HISTORY

Yolanda was admitted to the children's home with two of her sisters in September 1990. Her eldest sister, Beauty, had been admitted there in the previous year.

At this stage Yolanda and her younger sisters were street children. They were found living on the content of dirt-bins. They were in an extremely neglected state as they had lost Beauty who had previously provided for them by stealing, etc.

Yolanda's upbringing was similar to Beauty's, but as a younger child she experienced even more deprivation than her older sister. According to Beauty, Yolanda in particular, had been severely physically abused by her violent and alcoholic relatives. In one of the brawls, Yolanda sustained an injury to her head. A large wound resulted which never received attention. It went on suppurating, emitting a foul-smelling pus. The depressed scar of this wound is still evident.

Numerous violent scenes were witnessed by Yolanda. Amongst them were the lethal stabbing of her mother's male friend by her mother. Another was

a violent attack on their home by tsotsis, who looted, smashed bottles, stabbed people and burned property.

When her mother was away in the Transkei, Yolanda was sexually abused by the male companion in whose care she was left by her mother and whom her mother ultimately stabbed to death.

She became a street child when her mother was imprisoned and the children were rejected by relatives.

2.6.3. BEHAVIOUR AT THE CHILDREN'S HOME

The staff at the children's home regarded Yolanda as a **conduct-disordered child** on account of the following behaviour:

- **Fighting** with other children;
- **Disobedient** and cheeky towards the staff;
- **Tantrums;**
- **Blaming other children** for her behaviour;
- **Telling lies** whilst insisting that she had spoke the truth.

However, as Yolanda was always considered intelligent and did well at school many aspects of her behaviour were overlooked until she **became disruptive in the children's home** and the other children started avoiding her, **calling her *mad.*** It was at this stage, 11 months after her admission to this home, that Yolanda's case was presented to me at the Child and Family Unit. She was amongst a group of 8 children who required psychiatric diagnosis.

According to the staff, Yolanda had apparently always manifested these symptoms, but they had recently become intolerable.

2.6.4. PRESENTING SYMPTOMS AT PSYCHIATRIC CONSULTATION

- **Extreme anxiety:**
  Yolanda was a very **nervous** child who reacted in a bizarre way to certain **ordinary** experiences: for example, she became excessively anxious about the hospital visit, resisted coming, and said she was going to die;

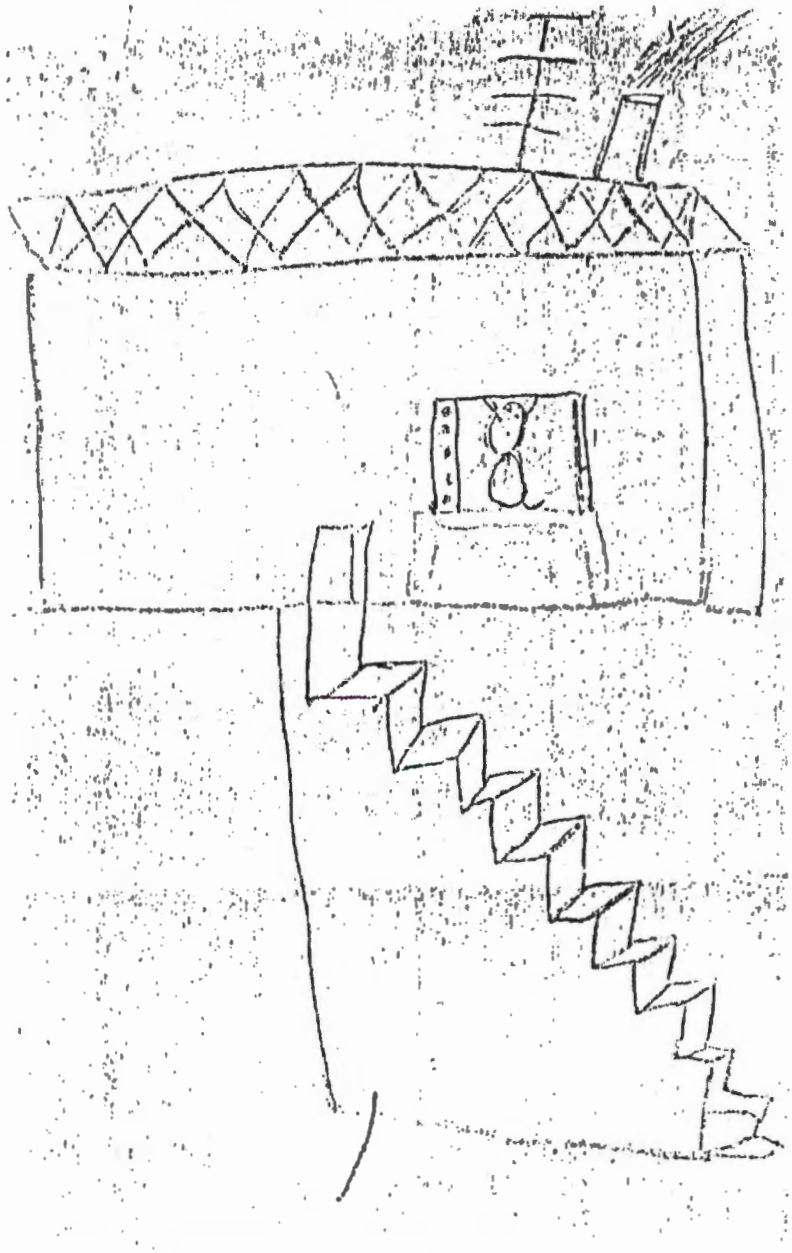
- **She slept restlessly at night**, awakening as if startled;

- **Bedwetting** had been a problem since her arrival;

- At times she was **preoccupied and inaccessible;**

PLATE VI

YOLANDA'S DRAWING



Yolanda depicted as "Tikie", her father's cat

- She **invented fantastic stories:**
  She claimed that they were true and also said her grandfather was a minister of religion;

- When reprimanded:
  She **cried excessively, laughed inappropriately, or went into a trance-like state;**

- Yolanda appeared to be unaware of her surroundings, dressed in rags and **did not respond to comments** about her appearance;

- She **manifested destructive play** with dolls: the theme of **physical abuse** was always the same and she would rip the clothes off the dolls.

The children found Yolanda's behaviour disturbing.

2.6.5. YOLANDA'S MENTAL STATE AT PSYCHIATRIC CONSULTATION

Yolanda presented as a **highly anxious**, small child. She bit her nails throughout the interview and looked around nervously.

The staff member who accompanied her attempted to put her at ease but she told him that she was expecting to have a brain transplant at the hospital. She imagined that her brain would be removed by a machine because she was *mad*. When asked why she thought she was *mad*, she said that **she kept thinking about the tsotsis attacking her home**. She smiled a lot at this stage and could not proceed further when asked about her own injuries.

She said that the wound on her head had been caused when she *bumped it*.

Yolanda denied that she had worries. She said that she was only concerned about being *mad* and *having a brain transplant* because her brain did not work well and she was always thinking about her home.

She also denied having any bad dreams. She said she only dreamed of having a lovely home with a lounge suite.

She wished to be successful in her studies and always to be neat and tidy.

Yolanda **would not draw any of her experiences** but depicted herself as her father's cat *Tikie* on the TV in her home (**see Plate VI** between p.79 and p.80). She could not tell me why she did this. However it was noted that the stairs to the house had been drawn with remarkable cognitive ability for her age (**see Plate VI** between p.79 and p.80).

2.6.6. PERSONAL BACKGROUND AND PREMORBID PERSONALITY

Yolanda did not have the same father as Beauty, and her father's whereabouts are unknown. There is no information about Yolanda's birth and infancy. According to Beauty, the children had to fend for themselves at a very early age and Yolanda seemed to bear the brunt of the abusive environment in which the nine children grew up. Yolanda has been on the streets intermittently since she was 4 years old.

2.6.7. FAMILY BACKGROUND

Yolanda's family background has been the same as Beauty's, except that Beauty had stayed with her father's family on occasions, whereas Yolanda did not have this advantage. Her mother's relatives became unresponsive to Yolanda's mother's requests that they should care for her children. At this time Yolanda was about 3 years old and was being neglected and physically abused by the maternal grandparents and aunts.

2.6.8. COURSE AND MANAGEMENT

Despite the severity of Yolanda's symptoms (Appendix 1), **she received no specific treatment** for her post-traumatic stress reactions, because:-

- **Xhosa-speaking therapists** were not available;
- **Previous experience** had been that treatment in the psychiatric ward was not possible without a Xhosa-speaking professional in the ward;
- Yolanda was **doing well at school,** despite her anxiety;
- An arrangement had been made that Yolanda spend the **Christmas holidays with *relatives*** in East London and it was decided to assess her mental state following this holiday.

However, a low dose of Amitriptyline was prescribed, and Yolanda's careworker was made aware of her special needs as a traumatised child.

2.6.9. SIX-MONTH FOLLOW-UP

Yolanda had been with her mother during the holiday. Although the circumstances were still too unsatisfactory to consider sending the children home, Yolanda's mother had allegedly stopped drinking and was looking for work. Yolanda's **post-traumatic stress symptoms were improving, but she still manifested conduct-disordered behaviour and was bedwetting** (level of functioning 55: on C.G.A.S). A U.C.T. student group project had included Yolanda in group work and the staff felt that Yolanda made good use of the groups to *express herself*. She continued to

make satisfactory progress at school. The tricyclic antidepressant had not been continued longer than a month as it did not have any beneficial effect.

2.6.10. <u>ONE-YEAR - SIX-MONTH FOLLOW-UP</u>

Yolanda again spent the Christmas vacation in East-London with her relatives. She was an untidy, unruly, cheeky oppositional child with a *don't-care* attitude, but she now gets on well with her peers and no longer demonstrates the features of post-traumatic stress disorder. However, she continues to wet her bed and functions at 55 on the C.G.A.S.

PART III

CHAPTER 1: DISCUSSION

There have been a number of noteworthy findings in the case study. In particular, the study has drawn attention to the importance of the **social setting** in the recognition, presentation, course and management of P.T.S.D. in children.

The relevance of the social setting will be emphasised in the following discussion. The impact of some of the **modifying factors** outlined in the review will also be examined.

1.1. Difficulties in the recognition of P.T.S.D. in this group

The most striking finding in this study has been the **failure to recognise the children's symptoms as stress related for lengthy periods and to attribute their behaviour to other psychiatric disorders or misconduct** (see Appendix 5).

There is little doubt that an objective examination of the profound trauma experienced by this group of children, both individually and collectively, **should have alerted professional caregivers to the possibility of severe stress reactions in the children.** Yet in all cases there was a considerable delay in the diagnosis of P.T.S.D. despite knowledge of this trauma and obvious symptomatology in the children.

The following factors are proposed as contributing to this finding:

1.1.1. WIDESPREAD IGNORANCE ABOUT P.T.D.S. IN CHILDREN

This ignorance may be particularly prevalent in a society which has not fostered an active approach to alleviating stress in communities and where organisations such as *Save The Children's Alliance* had found it necessary to assume protective roles towards children. It is not surprising that in this society the sophisticated constellation of symptoms comprising P.T.S.D. is easily overlooked, when the **basic knowledge about children's reactions to stress has lagged behind acceptable Western standards.**

The case studies have provided abundant evidence of ignorance about P.T.S.D. at all levels.

1.1.2. OVERLOADED SERVICES

In these circumstances, the social services tend to bear the professional load of stressed communities. **Overburdened social workers** and staff at children's homes are engaged in ensuring that the basic instrumental needs of the children are met. There is a tendency for social agencies to withdraw once the relief of placement of an endangered child at a children's home has been ensured. Furthermore, in disadvantaged communities, children are often only placed in a children's home if their home environment is both inadequate as well as traumatising. In many cases the **trauma which the children have suffered may have been recorded but soon forgotten or overlooked** by the unskilled and often heavily taxed staff who are primarily concerned with the provision of basic care.

The children's home housing these children provides 1 care-worker per 10 children. In such circumstances it is hardly likely that the mental health needs of individual children would be adequately assessed, let alone the required support provided.

Cases 1 and 4 illustrate the tendency of professionals from social agencies to record and yet ignore the past traumatic events in their present appraisal of the children.

1.1.3. CONDITIONING EFFECT OF VIOLENCE ON ATTITUDES

In a troubled society such as South Africa where all forms of violence have assumed alarming proportions, isolated events tend to have little impact.. It is also probable that in such an environment **affectual responses to personal trauma may become blunted,** serving as part of a protective mechanism in individuals. Accordingly, children's traumatic experiences might be **thought of by adults as a way of life** which should be tolerated or at least best forgotten and not emphasised.

There are **many examples of inappropriate adult responses to the children's traumatic experiences in the case study**, but the adult reactions to sexual abuse in Cases 2, 3, and 5 appeared to be almost inhumane, let alone unsympathetic.

1.1.4. REPRESSIVE ATTITUDES

In the interests of the efficient running of crowded children's homes, the children are often **expected to behave adaptively**. When they manifest problematic symptoms, these may be viewed by the staff as ***difficult behaviour*** rather than stress related emotional disturbance. The tendency to view children's behaviour as deviant rather than disturbed is possibly increased by the fact that **staff are required at times to deal with several conduct disordered children** in some of our children's homes. Accordingly, the approaches to the symptoms are often disciplinary with the aim of eradicating the problematic behaviour.

The **emphasis on *good behaviour*** becomes part of the ethos of a children's home, particularly one which promotes religious adherence. Some children appear to derive much benefit and security from such a milieu but traumatised children might feel alienated and unsupported because they cannot meet the expectations of the home. They **get labelled *problematic* and become ostracised by other children**. In such circumstances the children are likely to **suppress their symptoms** rather than appear *deviant*. It is probable that the above factor operated to some extent in the delayed referral of Cases 2, 5 and 6 of the study. The ethos of the children's home housing these children is as described above, but on the other hand, the staff have demonstrated a willingness to accommodate conduct-disordered children in the home and to work with them.

1.1.5. PERSONAL PERSPECTIVES, CULTURAL BELIEFS & ATTITUDES

In interviewing the staff of the children's home and the children's caregivers, it became obvious that **personal attitudes to the children's symptoms differed** and to some extent appeared to be determined by the cultural background and/or training of the individual. Although careworkers at children's homes do attend courses on the care of children, it seems that the longstanding and deeply entrenched perspectives of some staff members may be difficult to change. A psychiatrically trained professional regarded the symptoms in Cases 2 and 5 as *psychotic*, whereas the same symptoms were referred to as *bad* and *like their mother's* by unskilled careworkers. In Case 4, symptoms were attributed to *hysterical behaviour in an epileptic child* by medical and psychiatric staff. The mother of this child was convinced that the child had been *bewitched*. Similar beliefs were held in Cases 1 and 2 by the mother and family respectively.

1.1.6. POLITICAL CLIMATE

In societies favouring power politics and patriarchal dominance, there may be a tendency to ignore the voices of the disempowered. As women and children (particularly black women and children) are powerless groups in our society, it is perhaps not surprising that these cases were overlooked for some time. Case 1 represents a striking example of failure to protect a child against patriarchal demands, presumably because the caregivers were under some misapprehension about the father's rights over his child.

1.1.7. CLINICIAN FAILURE

It has been found by experienced investigators that clinicians fail to recognise P.T.S.D. in children (McLeer, 1988). Some authors have suggested that this failure may result from **denial** of distress in children as part of the countertransference in severe cases (Benedek, 1984, 1985). In this study it is of interest that **records** kept by therapists and other professional attendants were amazingly **lacking in details of the**

traumatic events experienced by the children. These omissions may have resulted from the children's avoidance of these events, but could also have reflected the professionals' reluctance to confront the events in any detail.

While the above explanation of clinician denial is plausible and likely to account for some of the misdiagnoses, it is also probable that other factors combine to create difficulties in the South African context. Clinicians are not immune to **acquiring the attitudes of the society** in which they live. **Paternalistic attitudes** have always been prevalent in South Africa. It is, therefore, quite possible that approaches to **diagnoses are influenced** by a tendency to view symptoms as *hysterical* or indicating personality *weakness* if they present in powerless, young women.

1.1.8. CHILDREN CONCEAL TRAUMA-RELATED SYMPTOMS

It is well recognised that children conceal trauma-related symptoms for fear of upsetting adults (Yule, 1993 - reported in *Cape Times*, April 7, 1993).

Sexually abused children, in particular, are **unlikely to disclose P.T.S.D. symptoms unless clinicians ask specific questions** (McLeer, 1988). The children in this study had all been sexually abused and might not have been expected to reveal their post-traumatic symptoms unless specifically asked. It could even be postulated that as a group they may have had more reason to suppress their symptoms than other children because of their **appalling experiences of adult reactions to their distress.**

The suppression of symptoms by the these children represented a prominent finding in this study and proved to be extremely problematic in the follow-up of cases.

Eventually interviews with the children were abandoned as a means of assessing the persistence of symptoms, as the impression was gained that the children were mistrustful of certain questions, evaded others and generally gave unsatisfactory accounts of their functioning. As a result, the children's progress and course could not be followed in terms of the presence or absence of symptoms reported by them, but had to be determined using the C.G.A.S. scale, which allowed for general impressions of functioning given by the staff of the children's home.

1.1.9. SPECIFIC DIAGNOSTIC DIFFICULTIES RELATED TO THE P.T.S.D.

The review dealt with many of the factors which impact on the diagnosis of P.T.S.D. in children and which create difficulties for the diagnostician. Each case has illustrated at least one of these factors:

1.1.9.1. Rachel

The presence of a **major depression masked Rachel's P.T.S.D.** symptomatology for several months. In her **home and cultural environment,** her **bad dreams were regarded as acceptable** and not unexpected in the circumstances. They were not initially offered as part of her presentation.

1.1.9.2. Emily

Emily's multiproblematic background and poor scholastic ability **created the impression of deprivation rather than distress**. As in Rachel's case, her **bad dreams and bizarre imagery were given culturally appropriate interpretations,** and her behaviour was attributed to **extreme religious fervour**. Emily's **reactivity resembled the impulsive character of her mother** and the derogatory comments of staff members indicated that they believed that she was a *silly* girl as they imagined her mother was. Indeed, personality traits may have contributed to the histrionic aspects of Emily's behaviour.

1.1.9.3. Cynthia

The prominent symptoms of **avoidance, denial and dissociation in Cynthia's presentation** masked other symptoms of P.T.S.D. for a long period. Cynthia typically displays the features of the Type 2 disorders described by Terr (1987b) in which the child attempts to protect the psyche by **massive repression** after long-standing or repeated exposure to extreme events. Her case illustrates the difficulties in diagnosing traumatic stress at this stage in its course, when the symptoms are masked by the above defense mechanisms.

1.1.9.4. Nomsa

Nomsa's presentation, despite its dramatic impact on the medical staff, apparently created the most diagnostic difficulties because of the presence of an **underlying neurological disorder and bizarre conversion symptoms.**

1.1.9.5. Beauty

Beauty's conduct, sexual promiscuity and severely disturbed background suggests a **diagnosis of Conduct Disorder.** The difficulty of identifying post-traumatic symptoms in this impulsive adolescent can easily be appreciated, as any inappropriate behaviour was regarded as *acting out*.

1.1.9.6. Yolanda

Similarly, the numerous facets of Yolanda's problematic background and presentation have obscured the diagnosis of

P.T.S.D. In particular, a prominent feature of Yolanda's presentation has been the tendency to seek retribution through fantasy in her destructive play with dolls. This play contrasts strongly with Yolanda's customary facade of grandiosity and **pseudo-mature behaviour**. The *lies* which she tells so frequently about her *wonderful* background appear to represent the desperate attempt of her immature ego to compensate for the shattering effects of her past. Her **facade** provides a smokescreen for intense suffering and effectively disguises her severe symptomatology.

1.2. Case findings of interest

In the examination of the cases in this study there were other interesting findings which merit comment:

1.2.1. GENERAL IMPRESSIONS OF THE GROUP PRESENTATIONS

All the cases in the study presented wide-ranging and severe symptomatology (Appendix 1).

In the two cases in which a Reactive Index Score could be obtained, the scores recorded were above 60, indicating very severe P.T.S.D. (Appendix 2).

It is not surprising that severe psychopathology was found in this group of children. Not only were the children **exposed to unusual and catastrophic trauma** but in all cases **risk factors, as recently identified by Breslau** et al (1991), were present, namely:

- **Childhood separations,**
- **A family history of antisocial behaviour,**
- **Being a female.**

With regard to the last risk factor, being a female within the age range of this group might be an additional vulnerability factor. It will have been noted in the review that a higher persistent P.T.S.D. level has been demonstrated in latency-aged and adolescent girls (Green, 1991).

All the children were sexually abused by an adult male. In 5 of the 6 cases these males were **caregivers/parents**. Since recent studies have confirmed that **sexually abused children** are at high risk for P.T.S.D. (McLeer, 1991), and that abuse by fathers and/or trusted adults was common in these studies, **this group of children would have been at high risk for P.T.S.D. on the basis of similar findings.**

It is probable that young, black females from disadvantaged urban environments may be less resilient to stress than those from good homes,

because **moderating, protective factors (Rutter, 1979) are often absent** and, because as a group, young, disadvantaged, urban, black females have had less cause to cherish positive expectations for the future. This latter factor (i.e. **having positive expectations for the future**) has been found to be one of the four major variables in stress resilience in profoundly stressed, urban children in the U.S.A. (Wyman, 1992). The children in this case study **would have had scant hope of a positive future prior to diagnosis.**

All the factors discussed above have identified these children as a **high risk group** in our society who, in the present circumstances, surely must be particularly vulnerable to P.T.S.D. In addition, two of the children might have been at risk on account of possible brain injury (see Cases 4 and 6).

1.2.2. OTHER NOTEWORTHY OBSERVATIONS

In Case 1, Rachel demonstrated more anger towards her mother for abandoning her than towards her father, who was the perpetrator. She was afraid of her father but indicated that he had rights over her and that she could not expect mercy from him. There were similar findings in Cases 2 and 3, with **little anger being expressed towards the male perpetrators** in both cases. All three of these children **presented themselves as powerless and intensely sad**, but these feelings were expressed unconsciously by way of drawings, songs or dreams rather than verbally. The impression gained is that the **children felt that they had no right to complain by speaking out against authority.**

In Cases 1 and 2 the **perpetrator is depicted as a snake appearing in dreams**. Interestingly, the snake is commonly used by children in play to represent negative external forces (Allan, 1988). It may depict aggressive parents, siblings or a punishing agent who kills bad people. In some instances the snake is a phallic symbol (Rambert, 1964; Jung, 1964). It could be postulated that the snake, in these cases, represented one or all of the above images, but unconsciously might also be reflecting the **betrayal of the family by the father as the patriarchal protector**. In this regard Rambert has noted that snakes are occasionally used as *protectors* in children's play.

However, it must be stressed that these children did not appear to be consciously aware of negative feelings towards their fathers which they expressed in their dreams. Although they **acknowledged the brutality of the acts perpetrated by their fathers,** they did not hold them morally responsible for their betrayal. Instead, they accepted the family's explanation of their plight as witchcraft and **felt that in some way they themselves had been blameworthy for the abuse.**

All the children were noted to have **extremely low self-esteem**. Sometimes worthlessness was openly expressed, but there were also individual unconscious expressions of **powerlessness, mindlessness and degradation.**

Rachel depicted herself in drawings as a **street child** without hands **(see Plate II and Plate III)**. It is of interest that most of the children in this group expressed traumatic imagery by recalling dreams or in verse/song rather than in drawings.

In Cases 2 and 6 the ideas of being **mindless** were expressed either in dreams or openly.

In the case of Yolanda, **fears of losing her brain** at the hospital were extreme, as she believed it was damaged and useless. She drew herself as a cat without a mouth or paws on her father's television set **(see Plate VI)**.

Emily claimed that she was **mad, bad and stupid**.

The above findings seem to reflect the fact that the **children experience themselves as valueless and without minds of their own.** They present as a powerless group with no rights to protest against male authority.

On the other hand, some of the children apparently felt at liberty to **show anger towards their mothers** or female caregivers for failing them. Alternatively, as in Case 2, the mother was held up by the child as a symbol of purity and goodness even when in reality this was not the case. For many traumatised children **the mother may be the only available source of hope for survival let alone support**. In recent studies authors have reported that stress resilient girls viewed their mothers as more nurturant than stress affected girls (Wyman, 1992). These desperate appeals to mothers in individual cases might reflect the children's anguish at the failure of their only lifeline in such circumstances.

The case presentations displayed not only a full list of P.T.S.D. criteria, but **individual cases also manifested various features of the sexually abused child** (Brown, 1986).

In Rachel, **depressive and psychosomatic symptoms** were prominent. Emily was preoccupied with **guilt, shame and feelings of worthlessness** to the extent that she performed frequent **cleansing rituals** on herself. Cynthia's powerful **dissociative symptomatology** dominated her presentation and allowed her to appear untouched by her experiences. This feature, coupled with her intense **mistrust of people,** resulted in poor relationships and severely impaired functioning in a social milieu.

In Nomsa, **hysterical outbursts and pseudoseizures** caused havoc until the diagnosis of sexual abuse was made.

Beauty was **sexually promiscuous and manifested a profound disturbance in conduct,** suggestive of **borderline personality psychopathology** (Goldman, 1992).

Yolanda's **neglect of her own person, violent abuse of toys,** dissociative symptoms and tendency to live in a fantasy world characterised her presentation of a child who had been severely physically abused.

In addition to the above findings, the presentations of cases 5 and 6 reflected the children's exposure to ongoing maltreatment, neglect and physical abuse by caregivers (Cicchetti, 1989). **Stimulus-seeking and aggressive behaviour** featured prominently in their presentations.

1.3. Comments on the course of symptoms

With regard to the course followed by the individual cases, it has already been observed that there were **difficulties in collecting accurate data** about the persistence or absence of P.T.S.D. symptoms. It will be noted, however, that all the children appeared to improve in their level of functioning following diagnosis (Appendix 4). This improvement was particularly striking in Cases 1, 2 and 3. The reason for the improvement is not known, but it is likely that the attitudes of adults became more supportive after diagnosis. As treatment varied in each case, it is unlikely that a particular strategy was responsible for the apparent recoveries. **Three of the children are presently functioning well and are apparently relatively asymptomatic.** The extent to which these children may be suppressing symptoms is difficult to evaluate. They have all expressed wishes to return to their families despite the trauma, and it is conceivable that in some cases **symptoms would be suppressed** because the child believes that she has a better chance of returning to her family if she is symptom-free.

One symptom which has persisted and which has been presented by the child Emily at every follow-up visit, is **profound survivor guilt.** She had displayed a strong **ambivalent attachment to the sib** who died (see Emily's song p.59). In this case it would appear that the close, yet competitive, relationships between the female members of the family had a significant bearing on Emily's persistent guilt. She believes she is living well while her sister is dead and her mother is starving. Survivor guilt was also manifested in Cynthia towards a sib, whom she imagined was suffering in the abusive environment of her aunt's home. There had been a **competitive relationship between Cynthia and this sib**. She continues to express frequent fears for his safety. These cases have illustrated the personal meaning of a symptom such as survivor guilt for each subject. As

these symptoms have been **long-lasting and troublesome,** they might require treatment in their own right.

It is important to note that **all three of the children who are presently functioning well received significant support from adult caregivers**: in Rachel's case a positive and enduring relationship with her mother was re-established; Emily was eventually fostered by the social worker who had sponsored her in the home; and Nomsa has a good relationship with her careworker. Nomsa also receives support from her mother who visits her regularly.

In contrast to these cases, **the other three children have had no enduring relationships with adults.** Sadly in **only one case has it been possible to return the child to her family**. In the other cases the **families have disintegrated.** This finding highlights the difficulties which confront professionals in their work in the area of rehabilitation in socially disadvantaged cases. Much has been written on the merits of family work in intrafamilial sexual and physical abuse (Giarretto, 1980; Williams, 1980). This study, however, demonstrates how some families are **trapped in a cycle of intergenerational and community violence.** They do not have the economic viability or social support to withstand the effects of trauma and cannot protect themselves or work co-operatively with professionals. (Feinstein, 1964; Ciccheti, 1993).

The children in this study have largely been deprived of family life and stable relationships with primary caregivers, factors which have been found to promote stress resilience in traumatised children (Wyman, 1991).

It is interesting to note that while two of these children related well to their individual therapists and **were emotionally contained during the therapy, they appeared to regress when these supportive relationships were withdrawn**. For whatever reason, temporary support of this nature apparently had no enduring, beneficial effect on the mental well-being of the children and might even have resulted in a feeling of being let down once again when the therapy terminated.

1.4. Comments on therapeutic interventions

Therapeutic intervention for P.T.S.D. in children has tended to emphasise interpersonal coping rather than the intrapersonal experiences of the child, e.g. grief, anxiety, helplessness. While there have been short-term gains in children who have received **cognitive-educative** treatment, long-term follow-up has shown trauma has pervasive and long-lasting effects in some children despite this form of treatment (Dreman, 1990). It has been suggested that **abreaction** might be an important ingredient in the treatment of traumatised children if long-term adjustment is to be achieved (Dreman, 1990). The rationale for abreaction would be to **prevent post-traumatic dissociation** which has been found to be a strong predictor of

chronicity in adult studies (Davidson, 1992; Walker, 1992; Bremner, 1992).

In this study, **dissociation has been a troublesome symptom**, particularly in Cases 3 and 6, where it seemed that the children were simply unable to confront any of the brutality of their experiences. In the light of current knowledge these children might be expected to fare poorly and, in fact, **their course is consistent with present beliefs about the relationship between dissociation and chronicity in P.T.S.D.**

A review of psychotherapy for P.T.S.D. in adults has **revealed that various forms of psychotherapeutic intervention hold promise in the treatment,** viz., flooding, stress inoculation, psychodynamic approaches and hypnotherapy (Solomon, 1992). The **children in the study did not receive any of these forms of therapy nor any specific treatment** such as abreaction, desensitisation or image habituation (Vaughan, 1992) which would focus on the source of the P.T.S.D. itself (Appendix 6). The imagery associated with traumatic events was therefore not dealt with to any great extent in the treatment. However in Case 2, **music therapy re-evoked the traumatic events of the child's life and made it possible for her to re-experience the feelings associated with these events in an emotionally supportive setting.** It is interesting to note that this extremely traumatised child, who appeared to have few overt resources, has made good use of the therapy she received and the support that was provided by a caring adult.

The small number of cases do not allow for meaningful comments about the effect of other treatment strategies in this study.

It will be noted that only **two children received medication** during the course of their symptoms. Neither child appeared to benefit from Amitriptyline or Carbamazepine respectively with respect to their symptoms. As **these drugs were not selected specifically for alleviation of P.T.S.D. symptoms** but rather for depression in Case 1, and *seizures* in Case 4, their effects on hyperarousal were not carefully observed.

The need for studies which investigate the effect of medication in children on P.T.S.D. symptom eradication is clear, but they might prove difficult to evaluate because of the tendency of these children to suppress symptoms.

Finally, **approaches which address the specific needs of the sexually and physically abused child** have been largely neglected in these cases. This is not surprising. In Britain a survey performed by the N.C.H. (*National Children's Home*) in 1990 found that there were only a handful of centres offering specialist services to sexually abused children (Dillner,

1993). The reason given for this is that local services do not have the funds to develop specialist services. If this has been the situation in British communities where a special campaign is being launched by the N.C.H. to fund appropriate services for sexually abused children, it is not surprising that treatment of abused children in this country is hopelessly inadequate. Our social services are not able to cope with investigation and disclosure of the appalling sexual violence (*Cape Times*, June 11, 1993), let alone treatment.

In considering **an appropriate model for the treatment of children who have been severely abused,** as has occurred in this group, the use of a model which only deals with post-traumatic stress disorder (Eth, 1985), may not encapsulate sufficient aspects of the abusive experience and may be inadequate (Finkelhor, 1988). Finkelhor puts forward a *model* of **4 traumatogenic dynamics** which must be dealt with in sexually abused children:

- *Traumatic (and inappropriate) sexualisation,*
- *Betrayal of trust,*
- *Stigmatisation or blame,*
- *Powerlessness.*

In addition to the above, attention should be given to the children's often paralysing fear of isolation imposed by the secrecy and confusion surrounding experiences that they cannot fully comprehend. **All of the above dynamics have been prominent in this group of children. Sadly, even after recognition of trauma, the facilities have not been able to provide adequate treatment.**

1.5. Implications of the findings in the case study

While it is acknowledged that this small case study has its limitations and that conclusions cannot be drawn on the basis of the findings, it would be important to offer some reflections on the implications of the material presented.

1.5.1. IDENTIFICATION OF CASES

The findings suggest that **P.T.S.D. in this social context is easily overlooked** and that special efforts need to be made to ensure that cases are identified.

1.5.2. USE OF SPECIAL SKILLS/TECHNIQUES

The study has **demonstrated difficulty in eliciting P.T.S.D. symptoms, using a checklist or semi-stuctured interviews in this group of children.** Although it might be possible, despite language difficulties, to

obtain answers to the questions asked in these interviews, it is doubtful whether the interviews would provide valid data (reasons mentioned on pages 44, and 86). This finding reiterates the **need for ways of exploiting the richness of information given in unstructured interviews,** so that the data can be applied across research settings. Recent publications have reviewed the use of structured interviews in children and raised the issues of validity, expense, labour intensity and tediousness of these interviews (Hodges, 1993). It seems likely that children who have been traumatised by adults might co-operate less readily in a structured interview with an adult professional. These cases call for **special skills and techniques in interviewing children.** These techniques need to be developed and widely taught if cases are to be identified.

1.5.3. CURRENT PRACTICES

In children's homes a number of factors have been postulated as creating particular difficulties in the diagnosis of P.T.S.D. Furthermore **misdiagnosis and labelling are likely to add to a child's problems** especially when management is directed towards correcting behaviour rather than providing emotional support for the traumatised child. It seems that there is a **need for greater awareness in staff in children's homes about stress reactions in children.**

The findings in the study raise some **concern** about whether the current practice of placing traumatised children in children's homes addresses their special needs.

In poorly serviced communities the children's home may be seen as the panacea for all the needs of deprived and abused children. Yet **placement of the child in a children's home results in a number of losses** for a child not the least of which is the community itself which might have offered a measure of support in some cases. (Emily spoke sadly about missing the woman in a shop in her neighbourhood). The findings in the study suggest that **these children required an ongoing positive relationship with an adult** in order to function well after their traumatic experiences and that in most cases without outside adult assistance this did not seem possible at the children's home.

The **consequences of placing traumatised children** in a children's home without suitable arrangements for their ongoing support might well be negative in terms of healthy personality development. Distorted behavioural patterns are likely to be perpetuated if there is little opportunity of the change which could possibly be effected through a close relationship with a trusted adult. In this regard both Cynthia and Yolanda have shown **entrenched dissociative behavioural patterns.** Beauty also manifests distorted development. She already has the **features of adult Borderline**

Personality Disorder and demonstrates brief psychotic episodes which would fit the D.S.M.-111-R criteria for **Brief Reactive Psychosis.**

1.5.4. TREATMENT OPTIONS

With regard to **treatment options**, the study does not provide any answers about the effectivity of specific treatment strategies, but it does highlight the **need for the investigation of all forms of intervention** which might alleviate the severe symptomatology of P.T.S.D. in these cases and which would promote healthy personality development. The discussion has raised pertinent issues which apply to the treatment of P.T.S.D. in other studies and which appear to be very relevant to the management of P.T.S.D. in this context; viz.,

- **The need to deal with the imagery** of traumatic events;
- **The immediate attention to and prevention of dissociation;**
- **The exploration of resources within the child** so as to promote coping in this social setting;
- **The provision of ongoing and meaningful support.**

1.5.4.1. Adult support

The need for adult support has been emphasised in the discussion. However, **support which fosters dependence may perpetuate the state of powerlessness** which the children in the study have expressed. It is well known that sexually abused children tend to manifest dependant patterns of behaviour (Cicchetti, 1989). **Overprotective attitudes would not be helpful in such cases**, as the developmental tasks to be faced require **personal autonomy and coping skills** in the young individual. The beneficial effect of an acquired skill on self-esteem and life attitudes has been clearly demonstrated in the case of Emily. As a result of learning the skill of dressmaking Emily stated at the last follow-up visit that she would eventually be self-supporting and would have a home for her family. Emily's coping strategies might not have been developed were it not for the **opportunity** created for her by a concerned and insightful adult. The outcome in this case suggests that it is not only ongoing support which is required, but an **attitude in the caregiver which promotes the development of autonomy in the child.**

1.5.4.2. Family approach

With regard to models used in treating sexually abused children, these **cases challenge the relevance of the family systems approach** which seeks to bring about change in family interaction, beliefs and functioning. As rehabilitation of these families has not been possible, treatment should focus on the child's best interests using a ***traumatogenic model*** which concentrates primarily on the effects of the abuse on the child and the child's responses and needs (Glaser, 1991).

1.5.4.3. Religion

It is difficult to speculate about the **effect of the religious ethos** of the children's home on the children's ultimate development. Some of the children appeared to derive comfort from prayer and the belief in an all-caring male deity who would protect them. However, it is not clear whether this belief simply perpetuates a state of awe and obedience for patriarchal authority in such cases, or whether the children are personally strengthened by their religious practices.

1.5.4.4. Psychotherapy

Clearly, a great deal is yet to be discovered about appropriate psychotherapy for traumatised children, but there are **indications that the treatment should include both dealing with the traumatic events themselves and techniques which promote coping.** In this study music therapy has proved a useful means of evoking painful experiences and expressing these for children in this setting. The actual acquisition of a skill in this case was the end result of a goal defined in the course of in-patient treatment and pursued with encouragement by the child. The outcome in this case implies that **supportive treatment should be goal directed** and followed through to some useful conclusion.

1.5.4.5. Pharmacotherapy

While pharmacotherapy might have proved helpful in alleviating the acute distress and hyperarousal experienced by the children, close monitoring would have been essential to ensure efficacy of medication for specific symptoms.

CHAPTER 2:

RECOMMENDATIONS FOR CARE

On the basis of some of the implications of this study, the following recommendations are offered as being important requirements for the care of traumatised children in the South African setting:

2.1. Training of professionals and child-care workers

All professionals who work with children, should receive basic education in the recognition of stress reactions in children as part of their vocational training.

2.2. Interviewing techniques

The skills of conducting a non-threatening interview with a traumatised child should be widely taught to professionals. Ideally **the interview should be therapeutic for the child** and not just a means of gathering information as tends to be the purpose of structured interviews. The *therapeutic* interview used by Pynoos and Eth (1986) serves as a helpful basis for supporting the child, but is lengthy and probably needs modification in this setting. For sexually abused children, the profound influences of adult betrayal, loss of trust, shame, stigmatisation, fear of the interviewer and powerlessness have to be taken into account when symptoms are initially denied. **Psychodynamic insights and playing techniques have recently made a useful contribution to communication skills in the work with sexually abused children** (McMahon, 1992). Significantly, the **use of the metaphor** in interviewing the child allows the child to communicate experiences in a non-threatening way (McMahon, 1992; Alvarez, 1992). It is my belief that these communication skills and play techniques developed in psychotherapeutic centres could be usefully incorporated into the routine assessment of traumatised children in our communities.

2.3. Public awareness

Education of the public about stress reactions in children should be initiated, as part of a **proactive approach** in responding to the present stressors. Youth programmes might serve **exploratory, educative and supportive functions**, encouraging victims to present themselves without fear of stigma. Programmes should evolve which allow young people to acquire the **autonomy** they so desperately need in resolving some of their own problems related to stress. The **peer mediation youth project (Botha, 1992)** serves as a useful **model for empowering youth.** Traumatised children might be encouraged to participate in the development of programmes as a means of acquiring strength by way of

their contribution. However, **children need the continued interest of supportive adults in their efforts.** While these adults cannot always be professionals, some direction from professionals would be beneficial in the pursuit of appropriate programmes and therapeutic group interventions.

2.4. Specialised care for traumatised children

Specialised care for traumatised children ought to be available **in the community** and preferably located in a **homely centre** where children and their families would feel comfortable and not stigmatised as *mad, sick* or *bad.*

The centres should not only serve an investigative function but need to develop treatment strategies alongside assessment skills. Ideally they would become **centres of expertise** in offering support to the children and their families. They might be regarded as *secondary* care centres in terms of the proposed health care structure although they would not be administered or staffed by health care professionals.

The centres should be **run by social workers** who would be responsible for the administration and *development* of the centre. Psychologists in a part-time capacity could assist in devising appropriate interviewing techniques for the setting, training of group leaders and para-professionals to deal with families, children's groups, etc., and exploration of innovative ways of dealing with traumatic experiences. Some suggestions for intervention include *dream* groups, song, rhythm and other **evocative sessions** which might prove therapeutic in dealing with the resistant dissociative aspects of P.T.S.D. in the community setting. Helpful contributions in the area of group work with sexually abused children are discussed briefly by McMahon (1992). Other useful models of focused proactive intervention are being developed by S.C.O.S.A.C.(Standing Committee on Sexually-Abused Children) in the U.K. to enhance the self esteem and effectiveness of the non-abusing carer and child (Anderson, 1993).

The **monitoring of cases** using current coding charts of trauma variables, presenting symptoms, functioning, etc., of each child might contribute valuable information on the course and outcome of P.T.S.D. in various situations and would provide useful records for researchers in this very important area.

Lastly, the centres should perform the important function of **liaison with schools, children's homes and tertiary centres.** As community based resources they would be in a far better position to find foster and *host* parents for children in children's' homes and to **provide surrogate parents with the necessary education and support.**

With regard to the children in this study, it is likely that their severe symptomatology and emotional needs might have been recognised earlier and addressed more effectively had they been initially assessed and followed up at such a centre.

The recent opening of a trauma centre for victims of violence and torture in Cowley House, District Six (*Argus*, July 3, 1993, p.5) is a **significant step forward in providing holistic care for trauma victims**. However, the emphasis on trauma resulting from civil and political conflict will hopefully not draw the attention of professionals away from the countless children who are brutalised by trusted adults in our communities, as these experiences may well turn out to be the most damaging.

2.5. Trauma and children's homes

It will have been noted from the case histories in the study that the children's home was the only refuge available for the child victims of trauma, where they could be physically cared for and safe. As it is likely that many traumatised children will continue to be admitted to children's homes **all those who have experienced trauma should be screened and monitored for symptoms of P.T.S.D. by an experienced professional** in the team. Alternatively, they should be assessed at a specialised centre, as recommended above.

It is desirable that psychiatrically trained professionals provide **regular consultation services** to children's homes to ensure that staff are continually made aware of the possibility of psychiatric disorders such as P.T.S.D. in disturbed and problematic children.

Furthermore, the **staff of children's homes need a great deal of support in themselves confronting the traumatic ordeals of the many children at the home.** Without this support, denial may be the only way to cope with the work, but this attitude in care-workers is unlikely to provide meaningful mental health care for distressed children.

It is doubtful whether the severe stress reactions in the children of this study would have been recognised without psychiatric consultation.

2.6. Role of psychiatry

Although P.T.S.D. is regarded as a severe psychiatric disorder in children, it would not be possible for the limited child psychiatric services to cope with the assessment of the anticipated number of cases, let alone the social and environmental manipulation which is required in management.

However, **certain insights and special skills of child psychiatry could prove helpful if they were integrated in assessment and management strategies.** For example, the expertise of the child psychiatrist in interviewing children at different developmental levels and the use of play techniques in diagnosis (McMahon, 1992) can greatly facilitate investigation and therapeutic interaction with children. These skills need to be imparted as far as possible to professionals at specialised trauma centres. Towards this end, **regular courses might be held at tertiary centres to provide education in specialised areas** and to keep professionals informed about useful psychiatric research findings.

Child psychiatrists could act as **consultants to specialised trauma centres in complex cases and for those requiring medication**. Cases requiring admission would presently have to be referred to tertiary centres as secondary facilities for psychiatric admission of children are not available.

Psychiatrists should continue their interest in the field, visit established centres on a regular basis, contribute skills and insights where needed and participate actively in research.

CONCLUSION

Post-Traumatic Stress Disorder is a serious psychiatric disorder of childhood, presently believed to be prevalent, but frequently concealed.

A **review** of the presentation and course of Post-Traumatic Stress Disorder in childhood has demonstrated its wide-ranging phenomenology and revealed a somewhat pessimistic view about the effect of the disorder on personality development, particularly in abused children.

Severe P.T.S.D. has been discussed in six sexually abused young females who were placed at a children's home after their traumatic experiences.

These cases have been recorded **with a view to increasing awareness** about serious stress reactions in South African children, particularly those who are powerless to express their suffering.

In opening our eyes to trauma and its aftermath, we should not close our minds to more effective care for the victims.

Clearly, effective **care for traumatised children will require major changes in adult attitudes and revision of policies which affect the general welfare** of children.

However, it is my belief that one of the ultimate **goals of care should be to assist children to express their suffering, to speak for themselves and to be aware of their important role in reversing present trends.**

After all, today's children are tomorrow's adults, and it is they who will be the active social agents of change.

Emily was one of the child victims who was able to overcome the pain of her own experiences and to express concern for others. These were her words at our last meeting:

"I will have my own house where the children will be safe".

APPENDIX 1

P.T.S.D. SYMPTOM CHECK LIST IN THE 6 CASES

SYMPTOMS	C A S E S					
	1	2	3	4	5	6
Re-experiencing						
Recollections of trauma	x	x	x		x	
Bad dreams, nightmares	x	x	x	x	x	
Intrusive trauma-related thoughts	x	x	x	x	x	x
imagery		x	x			
sounds		x	x			
Repetitive acting out of trauma:		x		x	x	x
sexual acting out		x			x	
promiscuity					x	
play themes						x
Distressing reminders	x	x		x	x	x
Survivor guilt		x	x			
Avoidant behaviour						
Restricted social range (withdrawal detachment)	x	x	x	x	x	x
Restricted affect (including depression)	x	x	x	x	x	x
Numbing						
Avoidance of feelings about trauma		x	x	x	x	x
Inability to recall trauma			x	x		x
Avoidance of reminders	x	x	x	x		x
Dissociative episodes		x	x	x	x	x
Sense of bleak or foreshortened future	x	x		x	x	x
Loss of interest in significant activities	x		x			
Regressed behaviour		x		x	x	x
Hyperarousal						
Sleep disturbance	x	x	x	x	x	x
Irritability, anger, anxiety	x	x	x	x	x	x
Difficulty concentrating		x	x	x	x	
Hypervigilance	x			x	x	x
Exaggerated reactions	x			x	x	x
Physiological reactivity (enuresis, somatic symptoms)	x		x	x		x

APPENDIX 2

REACTION INDEX SCORES IN 2 CASES

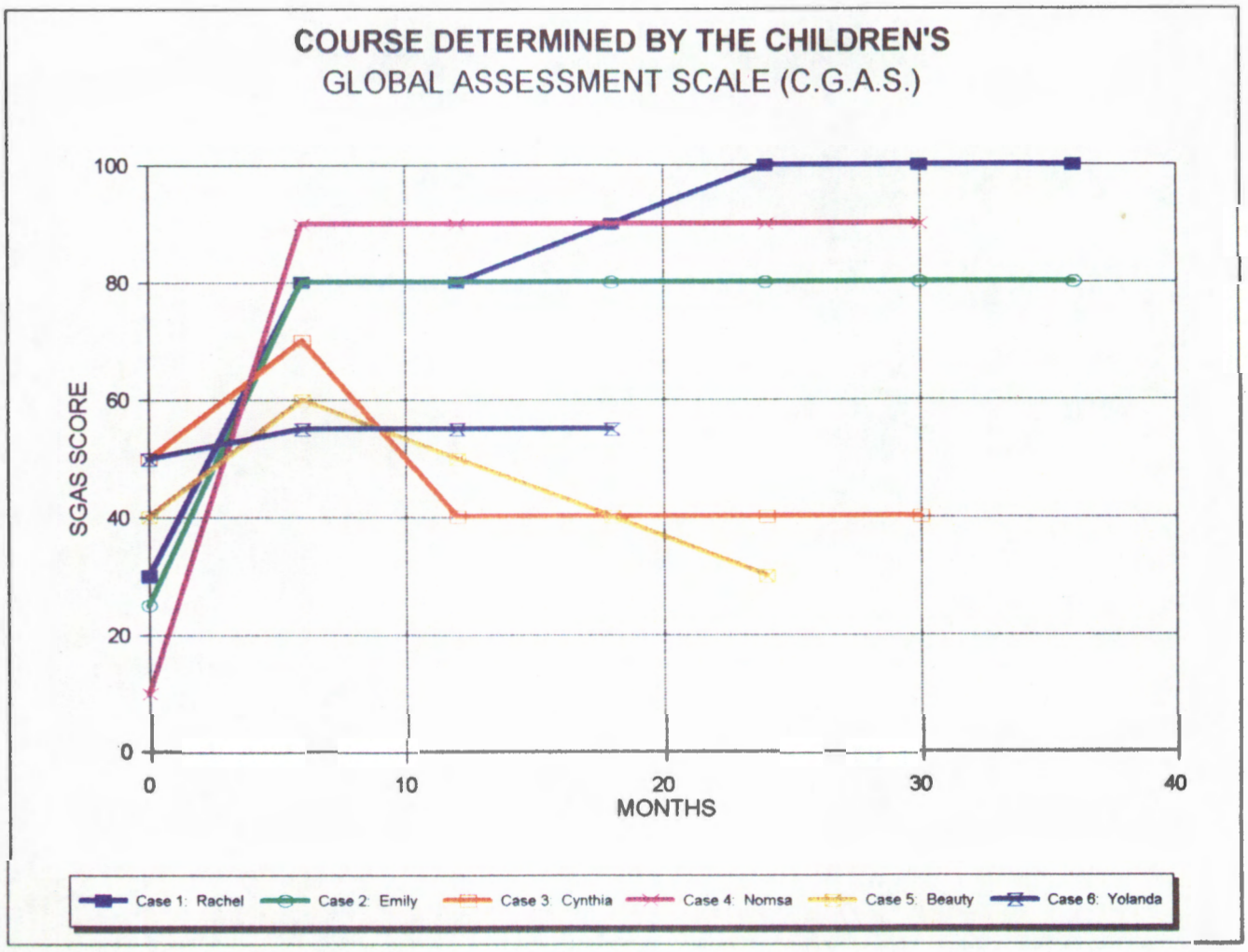
P.T.S.D. Reaction Index Item	Score Case 1	Score Case 2
Identifies event as extreme stressor	4	4
Afraid when thinks of event	4	4
Tense or upset in response to reminders	4	4
Intrusive images and sounds	3	4
Avoids reminders	4	3
Decreased interest in activities	3	3
Avoids knowing own feelings	2	3
Fears repeat of event	4	4
Reduced impulse control	4	3
Intrusive thoughts	3	3
More jumpy or nervous (startles)	4	3
Feels alone inside	2	2
Dreams of event/other bad dreams	3	3
Sleep disturbance	2	2
Feels guilty	3	4
Regression	2	4
Difficulty paying attention	2	3
Somatic complaints	2	2
Too upset to talk or cry	2	2
Thoughts of event interfere with learning	3	3
TOTAL SCORE	**60**	**63**

Scale: 4, most of the time; 3, much of the time; 2, some of the time; 1, once in a while; 0, never
Scores: 12 to 24 = mild; 25 to 39 = moderate; 40 to 59 = severe; >60 = very severe

APPENDIX 3

TRAUMA AND ABUSE VARIABLES	C	A	S	E	S	
	1	2	3	4	5	6
Sex of victim						
Male						
Female	x	x	x	x	x	x
Type of Physical abuse						
None						
Physical	x	x		x		
Severe physical			x		x	x
Age of onset of abuse (Phys & Sex.)						
None						
Infancy						
Child	x	x				x
Latency			x	x	x	
Adolescent						
Victim's Sexual Behaviour						
None	x					x
Preoccupation			x	x		
Promiscuity		x			x	
Perpetrator						
Both						
Sex of Perpetrator						
Male	x	x	x	x	x	x
Female						
Type of Sexual Abuse						
None						
Least serious with force						?x
Serious						
Serious with force				x		
Very serious		x				
Very serious with force	x		x		x	
Duration of Abuse (Phys.& Sex.)						
No abuse						
Single event						
Less than 1 year			x	? x		
1 - 5 years	x					
More than 5 years		x			x	x
Relationship of Perpetrator to Victim						
Biological parent	x	x			x	
Step-parent						
Adult sibling						
Child/adolescent sibling						
Other relative - adult						
Other relative - child/adolescent						
Adult care-giver			x			x
Child/adolescent care-giver						
Adult friend/acquaintance						
Child/adolescent friend/acquaintance						
Adult stranger				x	x	
Child/adolescent stranger						
Witnessing of Violence						
None			x			
Intrafamilial	x	x				
Intrafamilial (with threat to child's safety)					x	x
Extrafamilial						
Extrafamilial (with threat to child's safety)				x	x	x

APPENDIX 4


COURSE DETERMINED BY THE CHILDREN'S
GLOBAL ASSESSMENT SCALE (C.G.A.S.)
SGAS SCORE
100
80
60
40
20
0
0
10
20
30
40
MONTHS
Case 1: Rachel
Case 2: Emily
Case 3: Cynthia
Case 4: Nomsa
Case 5: Beauty
Case 6: Yolanda

APPENDIX 5

REFERRAL CHARACTERISTICS

CASE	REFERRAL AGENT	DURATION OF SYMPTOMS PRIOR TO REFERRAL	PROBLEMS PRESENTED BY REFERRAL AGENT	DIAGNOSES ON REFERRAL
1	Social worker social agency	> 12 months	withdrawal loss of intrest	Depression
2	Superintendent children's home	9 months	bizarre behaviour "slow" sexual acting out nightmares	Psychosis Mental retardation
3	Superintendent children's home	> 12 months	moody behaviour irritability "visions" and "voices"	Mood Disorder
4	Paediatric registrar emergency ward	> 12 months	"bizarre" pseudoseizures school absence	"Hysteria" Conversion Disorder
5	Medical officer casualty	> 12 months	anti-social behaviour sexual promiscuity aggression trance-like states	Conduct Disorder Psychosis
6	Superintendent children's home	11 months	aggressive behaviour destructive play trance-like states anxiety	Conduct Disorder "Hysteria"

APPENDIX 6

TREATMENT IN 6 CASES

CASES	TREATMENT	DURATION
1	Tricyclic antidepressant	3 months
2	Therapeutic milieu in ward Music therapy	6 months 6 months
3	Therapeutic milieu in ward Psychotherapy	3 months 6 months
4	Therapeutic milieu	1 week
5	Psychotherapy	6 months
6	Group therapy Tricyclic antidepressant	short course

APPENDIX 7

DSM-III-R DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g. serious threat to ones life or physical integrity; serious threat or harm to ones children, spouse, or other close relatives and friends; sudden destruction of ones home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently re-experienced in at least one of the following ways:
   (1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
   (2) recurrent distressing dreams of the event
   (3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)
   (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:
   (1) efforts to avoid thoughts or feelings associated with the trauma
   (2) efforts to avoid activities or situations that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma (psychogenic amnesia)
   (4) markedly diminished interest in significant activities (in your children, loss of recently acquired developmental skill such as toilet training or language skills)
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect, e.g. unable to have loving feelings
   (7) sense of foreshortened future, e.g. does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating
   (4) hypervigilance
   (5) exaggerated startle responses
   (6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g. a woman who was raped in an elevator breaks out in a sweat when entering an elevator)

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month after the trauma.

   Specify delayed onset if the onset of symptoms was at least six months after the trauma.

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